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DISPUTE RESOLUTION PRACTICE CODE

Third Edition

April 15, 1997

CODE DES PRATIQUES POUR LE RÈGLEMENT DES DIFFÉRENDS

Troisième édition

15 avril 1997

Ontario Insurance Commission
Commission des assurances de l'Ontario

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Ontario
Insurance
Commission

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Table of Contents

Preamble

Introduction ..... Intro 1

Organization of the Code ..... Intro 3

Where to Obtain Additional Copies of the Code and Forms ..... Intro 4

Some Answers to Questions Frequently Asked by Claimants ..... Intro 6

Section A – Rules of Procedure

Part 1

General Rules for Dispute Resolution ..... A 1-1

1. Interpretation ..... A 1-1
2. Guidelines ..... A 1-1
3. Practice Notes ..... A 1-1
4. Definitions ..... A 1-1
5. Commission Services and Documents ..... A 1-3
6. Filing ..... A 1-3
7. Service ..... A 1-4
8. Calculation of Time ..... A 1-5
9. Representation and Authority to Bind ..... A 1-5
10. Party under Disability ..... A 1-6
11. Time Limits for Mediation, Neutral Evaluation or Arbitration ..... A 1-6

Part 2

Mediation ..... A 2-1

12. Application for Mediation ..... A 2-1
13. Appointment of a Mediator ..... A 2-1
14. Response to Application for Mediation ..... A 2-2
15. Combining Applications ..... A 2-2
16. The Mediation Process ..... A 2-2

17. Participation in Mediation ..... A 2-3
18. Confidentiality during Mediation ..... A 2-3
19. Time Limits for Mediation ..... A 2-3
20. Settlement of an Issue ..... A 2-4
21. Failure of Mediation ..... A 2-4
22. Report of Mediator ..... A 2-4
23. Clarification of Mediator's Report ..... A 2-5
24. Referral to Neutral Evaluation ..... A 2-5

PART 3

Arbitration at the Commission ..... A 3-1

25. Application for Arbitration ..... A 3-1
26. Agreement to Neutral Evaluation ..... A 3-2
27. Appointment of an Arbitrator ..... A 3-2
28. Response by Insurer ..... A 3-2
29. Reply by the Applicant for Arbitration ..... A 3-3
30. Combining Applications ..... A 3-3
31. Severing Issues ..... A 3-4
32. Exchange of Documents ..... A 3-4
33. Pre-Hearing Discussion ..... A 3-5
34. Hearings ..... A 3-5
35. Time Lines for Written Hearings ..... A 3-6
36. Evidence and Witnesses ..... A 3-7
37. Surveillance Evidence ..... A 3-7
38. Expert Witnesses ..... A 3-8
39. Reopening of Hearing ..... A 3-8
40. Neutral Evaluation through the Commission ..... A 3-8

AZO-8875

41. Case Summary for Neutral Evaluation ..... A 3-9
42. Termination of Neutral Evaluation ..... A 3-9
43. Opinion of the Neutral Evaluator ..... A 3-9
44. Report of the Neutral Evaluator ..... A 3-10
45. Referral to Arbitration ..... A 3-10

PART 4

Appeal of Arbitration Order ..... A 4-1
46. Appeal ..... A 4-1
47. Starting an Appeal ..... A 4-1
48. Time for Appeal ..... A 4-2
49. Response to Appeal ..... A 4-2
50. Reply by the Appellant ..... A 4-2
51. Written Submissions ..... A 4-2
52. Appeal by Respondent ("Cross-appeal") ..... A 4-3
53. The Appeal Process ..... A 4-3
54. Preliminary Conference ..... A 4-4
55. Non-participation ..... A 4-4
56. Interventions ..... A 4-4
57. The Intervention Process ..... A 4-5

PART 5

Variation or Revocation of an Order ..... A 5-1
58. Application for Variation/Revocation ..... A 5-1
59. Response to the Application for Variation/Revocation ..... A 5-2
60. Reply by the Applicant in a Variation/Revocation ..... A 5-2
61. The Variation/Revocation Process ..... A 5-2

PART 6

General Procedures for Hearings ..... A 6-1

62. Applicability of this Part ..... A 6-1
63. Orders ..... A 6-1
64. Enforcement of Orders ..... A 6-1
65. Orders Within Proceedings: Motions ..... A 6-2
66. Settlement ..... A 6-2
67. Withdrawal ..... A 6-3
68. Inability to Complete a Hearing ..... A 6-4
69. Adjournments ..... A 6-4
70. Language Services ..... A 6-4
71. Summons to Witness ..... A 6-5
72. Transcripts ..... A 6-5
73. Award of Expenses ..... A 6-6
74. Offer to Settle ..... A 6-6
75. Communication of Offer to Settle or Response to an Offer to Settle ..... A 6-7
76. Expenses of Representatives ..... A 6-8
77. Assessment of Expenses ..... A 6-8
78. Constitutional Question and/or Charter Issue ..... A 6-9
79. Waiver of Procedural Requirements ..... A 6-10
80. Testimony and Civil Proceedings ..... A 6-10

SECTION B – COMMISSIONER'S GUIDELINES

1. Guideline for Identifying Self-employed Individuals ..... B 1-1
2. Guideline for Statutory Accident Benefits Applications, the Claims Process and the Mediation Process (Bill 59) ..... B 2-1
3. Guideline for Statutory Accident Benefits Applications, the Claims Process and the Mediation Process ..... B 3-1

4. Guideline for Selecting the Nearest Designated Assessment Centre ..... B 4-1

5. Guideline for Identifying Students Who Qualify for The Student Non-Earner Benefit (Bill 59) ..... B 5-1

6. Guideline for Identifying Individuals Who Qualify for Education Disability Benefits ..... B 6-1

7. Guideline on The Management of Claims Involving Whiplash-Associated Disorders ..... B 7-1

8. Optional Indexation Benefit Guidelines ..... B 8-1

9. Transportation Expense Guidelines ..... B 9-1

Section C – Practice Notes

1. Using Medical Evidence to Support Your Claim for Accident Benefits ..... C 1-1

2. Reaching a Settlement Within the Dispute Resolution Process ..... C 2-1

3. Authority to Bind ..... C 3-1

4. Exchange of Documents ..... C 4-1

5. Mediator Referral to Neutral Evaluation ..... C 5-1

6. The Arbitration Pre-hearing Discussion ..... C 6-1

7. Attendance of a Witness to an Arbitration Hearing by Summons ..... C 7-1

8. Adjournments ..... C 8-1

9. Process for Settling Disputes Between Auto Insurance Companies (Reg. 283/95) ..... C 9-1

Section D – Fees and Assessments

1. Fees D-1

2. Insurer Assessment D-1

3. Payment of Fees - By the Insured Person D-2

4. Payment of Fees and Insurer Assessment - By the Insurer D-2

SECTION E – SETTLEMENT REGULATION

Excerpt from Regulation 664 of R.R.O. 1990, as amended by O. Reg. 780/93 made under the *Insurance Act,* Subsection 9.1 (Settlements - Statutory Accident Benefits) E-1

SECTION F – EXPENSE REGULATION

Excerpt from Regulation 664, R.R.O. 1990 as amended by O. Reg. 464/96 made under the *Insurance Act,* Subsection 12 (Criteria for Awarding Expenses) F-1

Schedule to Regulation 664, R.R.O. 1990 as amended by O. Reg. 464/96 (Dispute Resolution Expenses) F-1

SECTION G – FORMS

Forms G-1

Form A – Application for Mediation ..... G A-1

Form B – Application for Arbitration ..... G B-1

Form C – Agreement to Neutral Evaluation at the Commission (Fax-Back Form) ..... G C-1

Form D – Response by Insurer to an Application for Arbitration ..... G D-1

Form E – Statement of Service ..... G E-1

Form F – Reply by the Applicant for Arbitration ..... G F-1

Form G – Joint Statement for Neutral Evaluation at the Commission ..... G G-1

Form H – Notice of Appeal ..... G H-1

Form I – Response to Appeal ..... G I-1

Form J – Reply by the Appellant ..... G J-1

Form K – Application for Intervention ..... G K-1

Form L – Application for Variation/Revocation ..... G L-1

Form M– Response to the Application for Variation/Revocation ..... G M-1

Form N – Reply by the Applicant in a Variation/Revocation ..... G N-1

Form O – Summons to Witness ..... G O-1

Form P – Affidavit of Service for a Summons ..... G P-1

Introduction

This is the third edition of the Dispute Resolution Practice Code published by the Ontario Insurance Commission. The Code is a users' guide to resolving disputes which arise out of claims under the *Statutory Accident Benefits Schedule* (SABS). The Rules of Procedure in this Code apply to all new applications for dispute resolution as well as existing cases at the Commission as of April 15, 1997.

This Code reflects changes to Ontario's automobile insurance legislation with the introduction of Bill 59, the *Automobile Insurance Rate Stability Act, 1996* and incorporates improvements arising out of extensive consultations with key users of the dispute resolution system. The Code creates rules for cost-effective and efficient dispute resolution services through the Commission.

Dispute resolution for disputes between insurers and insured persons about statutory accident benefits has been available in Ontario since 1990. Today, dispute resolution through the Commission includes mediation, neutral evaluation, and arbitration. The Office of the Director of Arbitrations at the Commission also offers an appeals process on questions of law, as well as variations and revocations of arbitration orders.

If you are unable to resolve a dispute with your insurer about statutory accident benefits, the first step in the dispute resolution process is mediation. Mediation of such disputes is mandatory in Ontario and must be conducted through the Commission before the dispute can proceed to court, private arbitration or arbitration through the Commission. No fee is charged for mediation. However, you must pay for your own expenses, which may include lawyer's fees, travelling expenses, accounting services, and additional medical reports.

Mediation is an informal process in which a mediator helps parties involved in a dispute about statutory accident benefits to clarify issues and find solutions that lead to a satisfactory outcome. The Commission achieves full or partial success in over 80% of mediations.

If you remain unable to resolve your dispute after mediation at the Commission, you have a number of choices. You may continue to negotiate with your insurance company directly, or pursue private neutral evaluation, private arbitration or court. Or you may opt for arbitration through the Commission, whereby you may engage in neutral evaluation through the Commission. Each option has its own rules, and you may not be able to switch from one system to another. For example, once you have commenced an action in court, you may not be able to switch to arbitration through the Commission, or vice versa.

This Code will help you move through the Commission's dispute resolution process. It explains what is required of everyone involved and sets out the Rules for such matters as the filing of documents, time limits and payment of fees and expenses. Of particular importance are the rights and responsibilities of insurers and claimants when dealing with statutory accident benefits claims. These rights and responsibilities are outlined in **Commissioner's Guidelines B 2-1** and **B 3-1**, which may be found in **Section B** of the Code.

It is important to note that the specific types of benefits, amounts, and eligibility requirements for benefits will differ depending on when your motor vehicle accident took place.

If your accident occurred:	**The applicable legislation is:**
• on or after November 1, 1996	• *Insurance Act* R.S.O. 1990 C.I.8., as amended, including amendments under the *Automobile Insurance Rate Stability Act,* 1996 [AIRSA], also known as Bill 59; and • *Statutory Accident Benefits Schedule – Accidents On or After November 1, 1996,* Ontario Regulation 423/96, as amended [referred to generally as SABS].
• on or between January 1, 1994 and October 31, 1996	• *Insurance Act* R.S.O. 1990, C.I.8. as amended by the *Insurance Statute Law Amendment Act,* 1993, also known as Bill 164; and • *Statutory Accident Benefits Schedule – Accidents After December 31, 1993 and Before November 1, 1996,* Ontario Regulation 776/93, as amended [referred to generally as SABS].
• on or between June 22, 1990 and December 31, 1993	• *Insurance Act* R.S.O. 1980, c.218 as amended by the *Insurance Statute Law Amendment Act, 1990, and consolidated by the Insurance Act* R.S.O. 1990 C.I.8, also known as the Ontario Motorist Protection Plan ("OMPP") or Bill 68; and • *Statutory Accident Benefits Schedule – Accidents Before January 1, 1994,* Ontario Regulation 672/90, as amended [referred to generally as SABS].

These rules DO NOT apply if your accident occurred on or before June 21, 1990.

If any provision of the Code is found to be contrary to the *Insurance Act* or any other law, then that law will prevail.

Organization of the Code

The Code has been divided into 7 sections.

Section A, the Rules of Procedure, consists of General Rules for Dispute Resolution, Mediation, Arbitration at the Commission, Appeal of Arbitration Order, Variation or Revocation of an Order, and General Procedures for Hearings.

Section B contains guidelines issued by the Commissioner on the interpretation and operation of the SABS.

Section C contains Practice Notes, which are issued by the Commission's Dispute Resolution Group to explain key elements of the dispute resolution process.

Section D sets out the applicable fees and assessments during the process.

Sections E and F contain the regulations on settlements and expenses, respectively.

Section G has copies of all the required forms.

For general information on mediation, neutral evaluation, arbitration and appeal, variation/revocation through the Commission, see **"Some Answers to Questions Frequently Asked by Claimants"**, which may be found at the end of the **Introduction** section.

The Code is designed to fit a 1 1/2 inch or 2 1/2 inch round ring binder with a clear insert sleeve on the front and spine of the binder. The pages have been three-hole punched to allow for easy insertion of updates issued by the Commission. These updates will be issued periodically as the need arises.

Where to Obtain Additional Copies of the Code and Forms

Additional copies of the Code and updates may be purchased from:

QL Systems Limited
Marketing Manager
1 First Canadian Place
Suite 930, Box 235
Toronto ON M5X 1C8
phone: (416) 862-7656

Publications Ontario
880 Bay Street
Toronto ON M7A 1N8
phone: (416) 326-5300
(800) 668-9938 (toll free)

Other outlets interested in selling the Code should contact the Commission's Director of Arbitrations at the address below. An updated list of all outlets selling the Code is maintained in the version of the Code posted on our website at http://www.gov.on.ca/OIC.

The Code can also be found at major public libraries, and in legal publications which report the Commission's decisions. An Application for mediation, arbitration, appeal or variation/revocation may be obtained from your insurance company. If you are having difficulty obtaining a form, you may write or telephone the Commission to have a single copy sent to you, as noted below. The mailing address for all forms is:

Ontario Insurance Commission
Dispute Resolution Group
5160 Yonge Street, P.O. Box 85
North York ON M2N 6L9

Or, you can telephone or fax your request for an application pertaining to:

Mediation:
Phone:(416) 250-6714 ext. 7210, or 1-800-517-2332 (toll free), ext. 7210
Fax: (416) 590-7077

Arbitration:
Phone:(416) 590-7202 or 1-800-517-2332 (toll free), ext. 7202
Fax: (416) 590-8462

Appeal, Variation or Revocation:
Phone: (416) 590-7020 or 1-800-517-2332 (toll free)
Fax: (416) 590-7077

Bulk orders of forms are available from printers such as:

Informco Inc.
35 Bertrand Avenue
Scarborough ON M1L 2P3
phone: (416) 285-1700

McCutcheon Business Forms
75 Hale Road
Brampton ON L6W 3J9
phone: (905) 451-3573

Lancaster Datamark
40 Nolan Court
Markham ON L3R 2V7
phone: (905) 475-9750

Some answers to questions frequently asked by claimants

What disputes can be brought to the Dispute Resolution Group at the Commission?

Our services help resolve disputes about whether or not you qualify for benefits under the *Statutory Accident Benefits Schedule* (SABS), and how much those benefits should be. You may use the services of the Dispute Resolution Group if an accident benefit has been claimed from your insurance company, and denied. The SABS deal only with injuries arising out of motor vehicle accidents that occurred on or after June 22, 1990.

We do not handle disputes about other types of insurance, such as car damage, personal property and disability insurance. Nor do we handle disputes between two or more insurers over which insurer is responsible for the payment of statutory accident benefits. These disputes must be referred to private arbitration under the *Arbitrations Act, 1991*. See **Practice Note 9**, - "Process for Settling Disputes Between Auto Insurance Companies", under **Section C** of the Code.

How do I start the dispute resolution process?

The first step is **mediation.** You must send a completed ***Application for Mediation* (FORM A)** to the Commission. (See part 2 of the Rules – Mediation.)

Mediation

What is mediation?

Mediation is an informal process in which a neutral third party (the mediator) helps the parties resolve the issue(s) in dispute. Mediators work with the parties to find acceptable solutions. They help clarify the issues and explore options that can lead to a satisfactory outcome. Mediators don't take sides and they don't have the power to impose decisions. Our statistics indicate that most disputes are settled at mediation.

How much will it cost?

There is no cost for mediation; the service is free of charge. However, you must pay for your own expenses, such as lawyer's fees, travelling expenses, accounting services, and additional medical reports.

In what languages are services provided?

Mediation services are available in both English and French. If you require assistance in another language, you must make the arrangements and pay the costs.

Do I need a lawyer?

Although a lawyer is not required in mediation, many people feel more comfortable having a lawyer help them with the process.

Should I be there?

Yes. Mediation can be conducted either in person or on the telephone (usually via a conference call). You have a responsibility to personally participate in the mediation process, even if you have a representative. If for some reason you do not participate, your representative must have full authority to bind you to any agreements which may be made. If your representative does not have this authority, your mediation may be delayed.

How long will it take?

The *Insurance Act* states that all mediations must be concluded **within 60 days.** In some cases this limit can be extended on written consent of all the parties.

What documents will I need?

You should try to provide copies of the best available documentation about your case. For medical disputes, this can include such things as doctor's reports, hospital reports, and physiotherapy reports. If your dispute is about the amount of your income, such things as tax returns, financial statements and bank records can be helpful. See **Practice Note 4** – "Exchange of Documents" under **Section C** of the Code.

Each party may ask the other for relevant documentation. If you fail to produce requested documents that the mediator considers necessary for settlement discussions, this will be noted in the mediator's report.

What if my dispute is not resolved in mediation?

If some issues remain unresolved at the end of the mediation, you have a number of choices. You may continue to negotiate with your insurance company directly, or pursue private neutral evaluation, private arbitration or court. Or you may opt for arbitration through the Commission, whereby you may engage in neutral evaluation through the Commission.

What is a Designated Assessment Centre?

Designated Assessment Centres, or DACs, are health care service providers appointed under the authority of the SABS to provide independent health care assessments of persons injured in automobile accidents in Ontario. You may be required to attend a DAC if your accident occurred on or after January 1, 1994. If you fail to attend without reasonable excuse, you may not be permitted to go to mediation or arbitration. See **Practice Note 1 -** "Using Medical Evidence To Support Your Claim for Accident Benefits" under **Section C** of the Code.

Neutral Evaluation

What is neutral evaluation?

Neutral evaluation is a process where a neutral third party (the neutral evaluator) provides the parties with an assessment of the issue(s) in dispute, as well as an opinion on the likely results if the dispute(s) were to proceed to arbitration at the Commission or to court. This assessment is intended to help the parties settle their dispute.

How do I obtain neutral evaluation?

Neutral evaluation is offered either privately or as part of the arbitration process at the Commission. You and your insurer may agree to refer your dispute to a private (non-Commission) neutral evaluator. The mediator may also make a referral. The Director of Arbitrations will appoint the person selected by the parties, upon their request.

If you want neutral evaluation through the Commission, you must file for arbitration at the Commission and both parties must agree to neutral evaluation.

How much will it cost?

Private evaluators set their own rates. The Commission is not responsible for the costs of private neutral evaluation and the terms of payment and cost must be negotiated between the parties and the selected evaluator.

Although there is no charge to the insured person for neutral evaluation conducted at the Commission, you must pay the $100 filing fee for arbitration.

What if my dispute is not resolved through neutral evaluation?

If you participated in private neutral evaluation, and the ***Report of the Neutral Evaluator*** has been issued, you may choose private arbitration under the *Arbitrations Act,* court, or arbitration through the Commission. If you completed neutral evaluation through the Commission, and all disputes did not settle, your file will automatically proceed through the arbitration process, but will normally be fast-tracked directly to an arbitration hearing, without the necessity of a pre-hearing discussion.

Arbitration at the Commission

What is arbitration?

Arbitration is a decision making process, similar to court. The advantages of arbitration are that it is quicker, less expensive and less formal than court. The arbitrator will listen to the witnesses called by each side, review all the evidence and make a binding order.

Who can apply for arbitration?

Only the insured person may apply for arbitration; the insurance company does not have this right. You may not apply for arbitration unless you have first gone to mediation with your dispute.

How do I apply for arbitration?

You must complete an **Application for Arbitration (FORM B)** and send it to the Commission, together with your **$100.00** filing fee.

How much will it cost?

Over and above the **$100.00** filing fee, you will also be responsible for your own expenses, such as witness fees, travelling and legal expenses, accounting services, additional medical reports and experts' fees. An arbitrator may award the expenses of a proceeding to either the insured person or the insurer. In awarding expenses to either party, the arbitrator will consider the factors described in **Rules 73 and 74** and under the **Expense Regulation** found in **Section F** of the Code.

In some cases the insured person may recover some or all of the expenses of the arbitration from the insurer, if the arbitrator so orders. Expenses awarded by the arbitrator are recoverable only up to the maximums set out in this Code under **Rule**

76 and under **Section F** – Schedule to the Expense Regulation. Legal fees are only recoverable at the rates set out in this Code under **Rule 76.** If your lawyer or agent charges more than these rates, you will be responsible for any additional amount.

In certain cases, the arbitrator may award the insurance company a portion of its expenses which the insured person will be responsible for paying. See **Rule 73** and the **Expense Regulation** found in **Section F** of the Code.

As well, if the arbitrator concludes that your claim was frivolous, fraudulent, vexatious or an abuse of process you may be ordered to pay an additional amount up to the amount of the assessment the insurance company has paid. See **Fees and Assessments** found in **Section D** of the Code.

In what languages are services provided?

Arbitration hearings may be held in English or French at the request of the applicant. Interpretation services in other languages may be provided by the Commission as determined by the arbitrator.

Do I need a lawyer?

A lawyer is not required for arbitration, but most people are represented. Insurance companies are nearly always represented by lawyers at arbitration. You are encouraged to at least consult a lawyer.

What documents are required?

As in mediation, you should have independent documentation about your claim. You and the insurance company should have already exchanged the relevant documents. These should also be provided to the Commission. If necessary, an arbitrator at the pre-hearing may order the production of other important documents. It is in the best interests of both parties to comply with an order for production in a timely manner. See **Practice Note 4**, "Exchange of Documents", under **Section C** of the Code.

Should I be present at the arbitration hearing?

Yes. Arbitration hearings are usually held in person either at the Commission's offices in North York or locations throughout Ontario. Sometimes the parties can agree to waive an oral hearing and the arbitrator's decision will be based on the documents filed and written arguments.

How long will it take?

The length of the arbitration process will vary depending on the nature and complexity of the case. The average length of an oral hearing at the Commission is two to three days.

Appeal, Variation/Revocation

What should I do if I think the arbitration decision is wrong?

If you think that an arbitration decision is wrong, two possible procedures are available to you. First, you can **appeal** the decision, but only where the arbitrator made an error of law. You will not be allowed to proceed in appeals simply because you think the arbitrator should have accepted your evidence instead of the other party's.

A ***Notice of Appeal*** **(FORM H)** must be filed **within 30 days** of the date of the arbitration decision. The filing fee is $250. Appeals are decided by the Director of Arbitrations or someone appointed by the Director.

The second option is an ***Application for Variation/Revocation*** **(FORM L).** This process is appropriate where the situation has changed since the arbitration hearing, where new evidence has become available that was not available for the arbitration hearing, or where there is some clear error in the arbitration decision. The filing fee for an ***Application for Variation/Revocation*** is $100.

How do I find a lawyer?

The Law Society of Upper Canada offers a lawyer referral service. For more information, phone (416) 947-3330.

Where do I get more information?

More detailed information is available through the Commission's recorded telephone information service at (416) 250-6714 or toll free at 1-800-517-2332.

SECTION A

RULES OF PROCEDURE

August 1, 1995

1. INTERPRETATION

1.1 These Rules will be broadly interpreted to produce the quickest, most just and least expensive resolution of the dispute.

1.2 Where something is not specifically provided for in these Rules, the practice may be decided by referring to similar Rules in this Code.

1.3 A defect in form or other technical breach will not make a proceeding invalid.

1.4 These Rules are made by the Director under the authority of section 21 of the *Insurance Act* and section 25.1 of the *Statutory Powers Procedures Act,* R.S.O. 1990, chapter s.22, as amended *[SPPA].*

1.5 Subject to the requirements of the *Insurance Act* and the *SPPA,* the Director of Arbitrations may make changes to these Rules at any time, if she or he considers it appropriate.

2. GUIDELINES

2.1 The Commissioner may publish guidelines on the interpretation and operation of the *Statutory Accident Benefits Schedule (SABS).* Guidelines are found in **Section B** of the Code.

2.2 These guidelines shall be considered when interpreting the *Statutory Accident Benefits Schedule.*

3. PRACTICE NOTES

3.1 The Commission may issue *Practice Notes* about the policies and administrative procedures of the Dispute Resolution Group. *Practice Notes* are found in **Section C** of the Code.

3.2 *Practice Notes* are not binding and do not affect the duty of the adjudicator to make decisions based on the circumstances in the case.

4. DEFINITIONS

4.1 In these Rules:

"accident benefits" means benefits under the *Statutory Accident Benefits Schedule;*

"Act" means the *Insurance Act,* R.S.O. 1990, c. I.8, as amended;

"adjudicator" means the Director, or person appointed by the Director under the *Act* to conduct the pre-hearing discussion, arbitration hearing, preliminary conference, appeal or variation/revocation proceeding, as the case may be;

"appeal" means an appeal in accordance with section 283 of the *Act* as amended;

"arbitration" means an arbitration in accordance with section 282 of the *Act* as amended;

"arbitrator" means an arbitrator appointed by the Director under Section 282 of the *Act* as amended;

"Commission" means the Ontario Insurance Commission;

"Director" means the Director of Arbitrations appointed under section 6 of the *Act* or a person to whom the Director has delegated his or her powers or duties;

"document" includes written documents, forms, reports, charts, films, photographs, transcripts, videotapes, audio tapes, and computer files;

"electronic hearing" means a hearing held by conference telephone, or some other form of electronic technology allowing persons to hear one another;

"to file" means to file with the Registrar;

"hearing" means the opportunity to state one's case before an adjudicator in the context of an oral, written or electronic hearing;

"mediator" means a mediator appointed by the Director under section 280 of the *Act*;

"neutral evaluation" means an evaluation under section 280.1 of the *Act* of the probable outcome of a proceeding in court or arbitration;

"neutral evaluator" means a person appointed by the Director under section 280.1 of the *Act*;

"oral hearing" means a hearing at which the parties and/or their representatives attend in person before an adjudicator;

"private arbitration" means an arbitration under the *Arbitrations Act, 1991*;

"private neutral evaluator" means a person who has been appointed by the Director under section 280.1 of the *Act* to perform an evaluation of the probable outcome of a dispute, other than a person appointed to perform the evaluation through the Commission under **Rule 26.2** of the Code;

"Registrar" means the Office of the Registrar, Dispute Resolution Group, Ontario Insurance Commission;

"serve" means the effective delivery of a document to a person as permitted by these Rules;

"Statutory Accident Benefits Schedule" means any of the following:

(a) the *Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996* for accidents that occur after October 31, 1996 or;

(b) the *Statutory Accident Benefits Schedule — Accidents after December 31, 1993 and Before November 1, 1996* for accidents that happened on or between January 1, 1994 and October 31, 1996 inclusive; or

(c) the *Statutory Accident Benefits Schedule — Accidents Before January 1, 1994* for accidents that happened on or between June 22, 1990 and December 31, 1993 inclusive.

"written hearing" means a hearing held by means of the exchange and filing of documents.

5. Commission Services and Documents

5.1 A person has the right to communicate in French, and to receive available services in French from the Commission as provided in the *French Language Services Act,* R.S.O. 1990, c.F.32.

5.2 The Commission may issue letters of direction, notices and other documents signed by the Registrar.

6. Filing

6.1 Where these Rules require a document to be filed:

(a) the document must be delivered to the Registrar;

(b) one of the methods of delivery permitted under **Rule 7** must be used; and

(c) the time frames set out in **Rule 7** apply.

7. SERVICE

7.1 A document must be served by one of the following methods:

(a) personal delivery;

(b) regular, registered, or certified mail;

(c) courier service, including Priority Courier;

(d) facsimile;

(e) document exchange on a person who participates in an exchange service; or

(f) any other manner specified by the Director.

7.2 A document that is served by facsimile must include a cover page indicating:

(a) the name, address, and telephone number of the sender;

(b) the name of the individual to be served;

(c) the date and time the document is being sent;

(d) the total number of pages being sent including the cover page;

(e) the telephone number from which the document is being sent; and

(f) the name and telephone number of a person to contact in the event of a problem.

7.3 Service by a party or delivery by the Commission will be considered to take place within the time frames set out below:

(a) if a document is served by personal delivery, service takes place on the day delivery is made;

(b) if a document is served by regular, registered, or certified mail, service takes place on the fifth day after the day the document is mailed;

(c) if a document is served by courier service, including Priority Courier, service takes place on the earlier of receipt, or on the second day after the document is given to the courier;

(d) if a document is served by facsimile, service takes place on the day that the document is sent;

(e) if the document is served by means of a document exchange on a person who participates in an exchange service, service takes place one day after the deposit, if the document is date stamped in the presence of the person depositing the document;

(f) if a document is served by any other means specified by the Director, service takes place within the time specified by the Director.

8. Calculation of Time

8.1 To calculate time under these Rules or an order:

(a) where there is a reference to a number of days between two events, they will be counted by excluding the day on which the first event happens and including the day on which the second event happens;

(b) where the time for doing an act under these Rules ends on a Saturday, Sunday, or a statutory holiday, the act may be done on the next day that is not a Saturday, Sunday, or a statutory holiday; and

(c) filing or service of a document **after 4:45 p.m.** or on a Saturday, Sunday or a statutory holiday will be considered to be made on the next day that is not a Saturday, Sunday, or a statutory holiday.

9. Representation and Authority to Bind

9.1 The mediator, neutral evaluator or adjudicator, as the case may be, may adjourn a proceeding, on such terms as he or she considers appropriate, if a party is not present and the representative of the insurer or insured person is not authorized to bind that party to any agreements that may be reached.

9.2 The Registrar, mediator, neutral evaluator or adjudicator, as the case may be, may request a party to provide written confirmation that the representative of the party has complete authority to bind that party.

9.3 A party who changes his or her representative must promptly notify the former representative, the other parties and the Commission, in writing, of the name, address and telephone number of the new representative.

9.4 A party who is represented and wishes to act on his or her own behalf, may discharge the representative by notifying the representative, the other parties and the Commission, in writing.

9.5 A representative who wishes to withdraw from an adjudicative proceeding shall notify the Commission and the parties, in writing. Where the party represented consents to the withdrawal, the Registrar shall permit the withdrawal. Otherwise, an adjudicator may permit the representative to withdraw subject to such terms as the adjudicator considers appropriate.

10. Party under Disability

10.1 A minor, or a person who is mentally incapable, within the meaning of section 6 or 45 of the *Substitute Decisions Act,* 1992, S.O. 1992, c.30 must be represented by one of the following:

(a) a litigation guardian;

(b) a parent, or legal guardian of the person's property as the case may be; or

(c) a court-appointed guardian.

11. Time Limits for Mediation, Neutral Evaluation or Arbitration

11.1 A mediation, neutral evaluation or arbitration must be started no later than:

(a) **2 years** from the date the insurer refused to pay an amount claimed; or

(b) as provided in the *Statutory Accident Benefits Schedule.*

11.2 Despite **Rule 11.1**, an insured person may apply for arbitration **within 90 days** after the mediator reports to the parties in the ***Report of Mediator*** or **within 30 days** after the neutral evaluator, appointed by the Director, reports to the parties in the ***Report of Neutral Evaluator,*** whichever is later.

12. APPLICATION FOR MEDIATION

12.1 An insured person or an insurer may apply for mediation of any dispute about an insured person's entitlement to accident benefits or the amount of those benefits.

12.2 A party who applies for mediation must file:

(a) a completed ***Application for Mediation*** in **FORM A,** describing the issues in dispute;

(b) a copy of the insurer's written explanation or ***Explanation of Benefits Payable by Insurance Company*** form, if any;

(c) a copy of all available documents that the applicant intends to refer to in the mediation; and

(d) if the applicant is the insurer, the name, address, telephone and facsimile numbers of its representative.

12.3 If it appears that an ***Application for Mediation*** is incomplete, or exceeds the jurisdiction of the Commission, the Commission will:

(a) deliver written notice of the jurisdictional concerns or deficiencies in the ***Application*** to the Applicant and their representative, and

(b) hold the ***Application*** in abeyance for **20 days** from the delivery of the notice.

12.4 Where the Applicant fails to address the jurisdictional concerns or rectify the deficiencies set out in the written notice within the **20 days** provided under **Rule 12.3(b),** the Commission may reject the ***Application.***

12.5 A party may not reapply for mediation of any dispute that has been previously mediated.

13. APPOINTMENT OF A MEDIATOR

13.1 On receipt of a completed Application for Mediation:

(a) the Commission will deliver a copy of the ***Application*** to the other party; and

(b) a mediator will be appointed promptly.

14. Response to Application for Mediation

14.1 The party responding to the ***Application for Mediation*** must, **within 10 days** of receiving the application, file:

(a) particulars concerning any additional issues to be mediated;

(b) if the party is represented, the name, address, telephone and facsimile numbers of the representative; and

(c) if the respondent is the insurer, a copy of the insurer's written explanation or *Explanation of Benefits Payable by Insurance Company* form if it was not included in the ***Application.***

14.2 The party responding to the ***Application for Mediation*** must serve on the other party a copy of all documents that the party intends to refer to in the mediation a**t least 10 days** in advance of the mediation meeting and file the documents.

15. Combining Applications

15.1 Where two or more ***Applications for Mediation*** have been filed involving the same parties or the same accident, the Commission may:

(a) combine the ***Applications***;

(b) schedule any mediation meetings to take place one immediately after the other; or

(c) on the consent of all parties, conduct any mediation meeting with all parties present at the same time.

16. The Mediation Process

16.1 Mediation may be conducted in person, by telephone, or by any other means that the mediator considers appropriate.

16.2 The mediator will look into all the issues in dispute and will help the parties settle as many of the issues as possible.

17. Participation in Mediation

17.1 The parties to the mediation and their representatives should be available for mediation within the time frames set out by these Rules, participate in good faith in the mediation process as required by the mediator, and exchange all relevant documents.

17.2 A failure to comply with **Rule 17.1** may result in a mediator reporting to the parties that mediation did not take place.

18. Confidentiality during Mediation

18.1 All statements and offers to settle made during mediation, except those contained in the ***Report of Mediator,*** are made for the purpose of settlement and shall not prejudice any position that the parties take in any arbitration or court proceeding.

18.2 A mediator shall not be required to testify in a civil proceeding or in a proceeding before any tribunal respecting a mediation or respecting information obtained in the discharge of the mediator's duties.

18.3 Where a party to a mediation provides information to the mediator in confidence, the mediator will not disclose the information without the permission of the party, unless required by law to do so.

18.4 If a party provides documents to a mediator in confidence, the mediator will return the documents to the party and the documents will not form part of the mediation file.

18.5 The Commission will not provide any part of the mediation file to a neutral evaluator or adjudicator, except the ***Report of Mediator.***

19. Time Limits for Mediation

19.1 Mediation will be completed **within 60 days** of the ***Application for Mediation*** being filed.

19.2 Despite **Rule 19.1** and subject to **Rule 21.1(a)** the parties may agree to extend the 60 day time limit.

19.3 Where the parties have agreed to extend the time limit, they must:

(a) inform the mediator; and

(b) confirm the extension in writing to the mediator.

20. Settlement of an Issue

20.1 Where the parties settle an issue on their own during the mediation process, they will advise the mediator of the terms of their settlement.

20.2 A settlement is subject to legal requirements, as applicable, including those governing final settlements See the **Settlement Regulation** found in **Section E** of the Code.

21. Failure of Mediation

21.1 Mediation has failed on an issue when:

(a) the mediator is of the opinion that mediation will fail and notifies the parties; or

(b) the time limit for mediation, including any extension, has expired and no settlement has been reached.

21.2 If mediation fails on any of the issues in dispute, the insurer will provide the mediator with its last offer in respect of such issue or issues.

21.3 No party may bring a proceeding in any court, refer the issues in dispute to an arbitrator, or agree to submit an issue to private arbitration unless mediation was sought and failed.

22. Report of Mediator

22.1 The mediator will record the following in the ***Report of Mediator:***

(a) the mediator's description of the issues that were in dispute;

(b) if any of the issues were resolved, the terms of any settlement;

(c) the insurer's last offer in respect of any issue that remains in dispute;

(d) any steps the parties agree to take to help them settle any issue that remains in dispute;

(e) a list of materials requested by the parties that have not been produced and that, in the opinion of the mediator, were required for the purpose of discussing settlement of any issue that remains in dispute; and

(f) the mediator's recommendation whether issues that remain in dispute should be referred to neutral evaluation.

22.2 The Commission will deliver a copy of the ***Report of Mediator*** to the parties, to a person appointed by the Director to perform a neutral evaluation, and to an arbitrator.

23. Clarification of Mediator's Report

23.1 If a party believes that the ***Report of Mediator*** is not accurate, the party should notify the mediator and the other parties in writing, with reasons, **within 10 days** of receiving the ***Report.***

23.2 After considering the reasons and the comments of the parties, the mediator may issue an amended ***Report of Mediator,*** if the mediator considers it appropriate.

24. Referral to Neutral Evaluation

24.1 If mediation fails on any of the issues in dispute, the parties jointly or the mediator who conducted the mediation may refer the issues in dispute to a person appointed by the Director for an evaluation of the probable outcome of a proceeding in court or arbitration.

24.2 Where the **mediator** refers the issues in dispute to neutral evaluation, the parties shall retain a private neutral evaluator appointed by the Director. See **Practice Note 5**, "Mediator Referral to Neutral Evaluation", under **Section C** of the Code.

24.3 Where the **parties** jointly refer the issues in dispute to neutral evaluation, the parties may:

(a) refer the issues in dispute to a private neutral evaluator; or,

(b) where an ***Application for Arbitration*** in **FORM B** has been filed with the Commission, the parties may request neutral evaluation through the Commission in accordance with **Rules 25** and following.

24.4 The Director will promptly appoint a person to conduct the private neutral evaluation upon receipt in writing of:

(a) the name, address and telephone number of the person who has been retained by the parties;

(b) confirmation that the person has agreed to perform the neutral evaluation at the parties' expense and in accordance with the requirements of the *Insurance Act*; and,

(c) the applicable Commission mediation file number.

24.5 Where the issues in dispute are referred to neutral evaluation, no party may bring a proceeding in any court, submit an issue for private arbitration, or participate in an arbitration hearing at the Commission unless the report of the person who performed the evaluation has been given to the parties.

25. APPLICATION FOR ARBITRATION

25.1 An insured person applying for arbitration must:

(a) file a completed ***Application for Arbitration*** in **FORM B,** describing the issues to be arbitrated;

(b) file a copy of the ***Report of Mediator*** related to the issues to be arbitrated;

(c) where an evaluation by a private neutral evaluator has occurred, provide the ***Report of the Neutral Evaluator*** or confirmation that the parties have received a copy of it; and

(d) pay the application filing fee set out in **Section D** of the Code.

25.2 The insured person may request neutral evaluation through the Commission in the ***Application for Arbitration,*** unless an evaluation by a private neutral evaluator has occurred.

25.3 The insured person should indicate on the ***Application for Arbitration*** whether he or she prefers an oral, written or electronic hearing.

25.4 If it appears that an ***Application for Arbitration*** has not been filed in accordance with the requirements of **Rule 25.1** or exceeds the jurisdiction of the Commission, the Commission will:

(a) deliver written notice of the jurisdictional concerns or deficiencies in the ***Application*** to the Applicant and their representative; and

(b) hold the ***Application*** in abeyance for **20 days** from the delivery of the notice.

25.5 Where the Applicant fails to address the jurisdictional concerns or rectify the deficiencies set out in the written notice within the **20 days** provided under **Rule 25.4(b),** the Commission may reject the ***Application.***

25.6 The Commission will deliver a copy of the completed ***Application for Arbitration*** to the other parties.

26. Agreement to Neutral Evaluation

26.1 Where the insured person has requested neutral evaluation through the Commission, the insurer may consent to neutral evaluation by completing an ***Agreement to Neutral Evaluation*** in **FORM C** and filing it by facsimile **within 10 days** of the receipt of the ***Application for Arbitration.***

26.2 Upon receipt of a completed insurer ***Agreement to Neutral Evaluation,*** the Director will:

(a) suspend the appointment of an arbitrator;

(b) promptly appoint a person to perform the neutral evaluation; and

(c) confirm the appointment with the parties.

26.3 Neutral evaluation through the Commission will be conducted according to **Rules 40** and following.

27. Appointment of an Arbitrator

27.1 Where the Director has not appointed a neutral evaluator under **Rule 26.2,** the Director will promptly appoint an arbitrator.

28. Response by Insurer

28.1 Where neutral evaluation does not take place, the insurer must, **within 20 days** of receipt by the insurer of the ***Application for Arbitration***:

(a) complete a ***Response by Insurer*** in **FORM D,** serve it on the insured person and any other parties; and

(b) file a copy of the ***Response*** together with a ***Statement of Service*** in **FORM E.**

28.2 The ***Response*** must:

(a) include a response to the issues raised in the ***Application for Arbitration;***

(b) include any additional issues which the insurer wishes to have arbitrated provided that they were submitted to mediation and failed; and

(c) indicate whether the insurer prefers an oral, electronic or written hearing.

28.3 The Commission may reject an incomplete ***Response.***

29. Reply by the Applicant for Arbitration

29.1 **Within 10 days** of being served with the ***Response by Insurer,*** the insured person must reply to any new issues raised by:

(a) serving a ***Reply by the Applicant for Arbitration*** in **FORM F** on the insurer and any other parties; and

(b) filing a copy of the ***Reply*** together with a ***Statement of Service*** in **FORM E.**

29.2 The ***Reply by the Applicant for Arbitration*** is optional where no new issues are raised in the ***Response by Insurer***.

30. Combining Applications

30.1 Where two or more ***Applications for Arbitration*** have been filed and it appears that:

(a) they have an issue or question of law, fact, or policy in common; or

(b) the application of this Rule will result in the quickest, most just, and least expensive means to deal with the ***Applications;***

The Commission will notify the parties that an arbitrator may order that:

(c) the proceedings be combined;

(d) the proceedings be heard at the same time;

(e) the proceedings be heard one immediately after the other;

(f) the proceedings be stayed until the determination of any one of them;

(g) evidence presented in one proceeding will be applied in another proceeding; or

(h) an order or decision made with respect to one proceeding be applied to the other proceeding.

30.2 If a party objects to an order made under this Rule, the party must notify the Commission and the other parties involved, in writing, of the objection.

30.3 The arbitrator may make an order under this Rule on such terms as he or she considers just.

31. Severing Issues

31.1 Where the arbitrator considers it appropriate, or where the parties agree and the arbitrator approves, the arbitrator may order that an arbitration application be divided into distinct issues and the arbitrator may hear the issues separately.

31.2 If more than one final order is made in an application, each order will stand on its own for the purposes of an appeal or a variation/revocation proceeding.

32. Exchange of Documents

32.1 **Before** a pre-hearing discussion, the parties must exchange the documents that are reasonably necessary to determine the issues being arbitrated. See **Practice Note 4** found in **Section C** of the Code.

32.2 At least **10 days before** the pre-hearing discussion, each party must:

(a) obtain and exchange those documents listed in the ***Report of Mediator*** as being required for the purpose of discussing settlement of the issues;

(b) exchange the documents in the party's possession on which the party intends to rely;

(c) identify any additional documents that the party intends to obtain from other sources prior to the hearing;

(d) identify documents that the party requests from any other party; and

(e) establish reasonable time frames for the exchange of the documents referred to in (c) and (d).

32.3 The parties have an ongoing responsibility to ensure the prompt and complete exchange of documents including updates to the information previously exchanged and any additional documents obtained.

32.4 An arbitrator may at any time order the production of any document or the giving of information that he or she considers relevant to the determination of the issues in the arbitration, on such terms as he or she considers appropriate.

32.5 If a party fails to produce documents that an arbitrator considers necessary to the determination of the issues in dispute, the arbitrator may:

(a) draw an adverse inference against the party who failed to produce the document;

(b) deny expenses to the failing party in accordance with **Rule 73;** or

(c) make such other order as the arbitrator considers appropriate.

33. Pre-Hearing Discussion

33.1 One or more pre-hearing discussions may be held before an arbitrator who will attempt to resolve the dispute, and will assist the parties to prepare for the arbitration by:

(a) identifying and obtaining agreement as to the issues for arbitration;

(b) obtaining agreement as to facts;

(c) deciding any disputes relating to the identification and exchange of documents;

(d) dealing with procedural and preliminary issues, and requests for interim relief;

(e) setting dates for the hearing and determining the hearing format;

(f) dealing with any other matters that the arbitrator considers appropriate.

33.2 A pre-hearing discussion may be held in person, electronically, or by any other means that the pre-hearing arbitrator considers appropriate.

33.3 The Commission will provide reasonable notice of a pre-hearing discussion to the parties.

33.4 The pre-hearing arbitrator will confirm the results of the pre-hearing discussion to the parties in writing.

33.5 The arbitrator who presides at the pre-hearing discussion at which the parties attempt to settle issues shall not preside at the hearing without the parties' consent.

34. Hearings

34.1 The arbitrator may:

(a) hold an oral hearing;

(b) hold a written hearing, with the consent of the parties;

(c) hold an electronic hearing; or

(d) hold a hearing which combines one or more of the above formats.

34.2 The arbitrator will only hold an electronic hearing if he or she is satisfied that holding an electronic hearing will not significantly prejudice a party.

34.3 The Commission will provide reasonable notice of a hearing to the parties.

34.4 The arbitrator will determine all issues in dispute and such other issues as the parties may agree.

34.5 Where notice of hearing has been sent to a party and a party does not attend at an oral or electronic hearing, or participate in a written hearing, the arbitrator may proceed with the hearing in the party's absence or without the party's participation, as the case may be, and the party is not entitled to any further notice of the proceeding.

35. Time Lines for Written Hearings

35.1 Where the parties agree to have a written hearing, the arbitrator:

(a) may, **within 30 days** after the last day on which the insured person is entitled to file a ***Reply by the Applicant for Arbitration,*** request additional materials or written submissions from the parties on any issue or matter in dispute;

(b) may proceed to determine the issues even though a party has failed to file additional materials or written submissions, if the arbitrator is satisfied that the party has received the request for additional materials or submissions;

(c) will make the order based on the materials and submissions filed;

(d) will issue an order on the later of:

(i) **60 days after** the last day on which the insured person is entitled to file a ***Reply;*** and

(ii) **30 days after** the last day on which the parties are required to file additional materials or written submissions.

36. Evidence and Witnesses

36.1 The arbitrator will determine the relevance, materiality, and admissibility of the evidence.

36.2 The arbitrator will not admit evidence at a hearing:

(a) that would not be admissible in a court by reason of any privilege under the law of evidence; or

(b) that is not admissible under the *Insurance Act*.

36.3 Every party must provide the Commission and the other parties with the names of the witnesses that the party intends to call **not less than 10 days** before the first day of hearing, or on such terms as the arbitrator considers appropriate.

36.4 If a party intends to introduce documents that have not been filed, the party must file the document and the information required by these Rules and serve a copy on the other parties as soon as possible, **but not less than 10 days** before the first day of the hearing, or on such terms as the arbitrator considers appropriate.

36.5 An arbitrator has the power to summon and enforce the attendance of witnesses and require them to give evidence on oath or otherwise, and to produce documents, records, and things.

36.6 The arbitration hearing may be recorded by a court reporter who has taken an oath or affirmation to report the evidence and proceedings faithfully.

37. Surveillance Evidence

37.1 If a party intends to rely on any portion of surveillance or investigative evidence, including videotapes, photographs, reports, notes and summaries of surveillance observations or investigations, the party shall provide:

(a) the names and qualifications of the persons who secured the investigative or surveillance evidence, the dates, times and places where any surveillance or investigation was undertaken; and

(b) copies of all videotapes, photographs, reports, notes and summaries taken or prepared by anyone upon whose evidence the party intends to rely at the hearing.

38. Expert Witnesses

38.1 If a party intends to introduce a report by an expert, the name and qualifications of the expert who prepared the report must accompany the report.

38.2 If a party intends to call an expert witness to present evidence at a hearing, that party must serve and file a document setting out the following **not less than 10 days** before the first day of the hearing, or on such terms as the arbitrator considers appropriate:

(a) the name and qualifications of the expert witness;

(b) the subject matter of the testimony to be presented; and

(c) the substance of the facts and opinion which the witness will present.

39. Reopening of Hearing

39.1 The arbitrator may reopen a hearing at any time before he or she makes a final order disposing of the arbitration.

39.2 **Rules 34 to 36** apply to the reopening with necessary changes.

40. Neutral Evaluation Through the Commission

40.1 **Within 30 days** of confirmation of the appointment of a neutral evaluator from the Director (see **Rule 26.2**), the parties must file a ***Joint Statement for Neutral Evaluation*** in **FORM G** containing:

(a) a description of the legal and factual issues to be evaluated;

(b) confirmation that all documents listed in the ***Report of Mediator*** and all other documents necessary for an evaluation of the issues have been exchanged by the parties; and

(c) two proposed half-day dates for the neutral evaluation which are no later than **60 days after** the date of the appointment of the neutral evaluator.

40.2 Upon receipt of the parties' ***Joint Statement,*** the Commission shall promptly select one of the dates for the neutral evaluation and shall notify the parties of the date, time, and location of the neutral evaluation.

41. Case Summary for Neutral Evaluation

41.1 At least **10 days prior** to the date of the neutral evaluation, each party must exchange and file a **case summary** containing:

(a) a summary of their submissions on the issues to be evaluated; and

(b) copies of the key documents required for an evaluation of each issue.

41.2 The parties shall promptly provide any additional information requested by the neutral evaluator.

42. Termination of Neutral Evaluation

42.1 A party withdrawing from neutral evaluation must notify the other parties and the Commission, in writing.

42.2 Where a party withdraws from neutral evaluation, fails to comply with any of the requirements for neutral evaluation as set out in **Rules 40 and 41,** or fails to attend or participate in neutral evaluation, the Commission may terminate the neutral evaluation.

42.3 Where neutral evaluation is terminated pursuant to **Rule 42.2,** the Director will promptly appoint an arbitrator.

42.4 **Rules 28** and following apply to an arbitration hearing conducted after the withdrawal from or termination of neutral evaluation under this Rule.

43. Opinion of the Neutral Evaluator

43.1 Where neutral evaluation proceeds, the neutral evaluator will give the parties an oral opinion on the probable outcome of a proceeding in court or an arbitration.

43.2 The opinion given in neutral evaluation is for the purpose of settlement and is confidential.

43.3 A neutral evaluator shall not be required to testify in a civil proceeding or in a proceeding before any tribunal respecting the evaluation or respecting information obtained in the discharge of the neutral evaluator's duties.

44. Report of the Neutral Evaluator

44.1 The neutral evaluator will promptly provide the parties with a ***Report of the Neutral Evaluator:***

(a) identifying the issues that were evaluated;

(b) identifying the issues that were settled; and

if any of the issues referred to neutral evaluation were not settled, the neutral evaluator will record:

(c) the issues that remain in dispute;

(d) the insurer's last offer in respect of such issues; and

(e) a list of materials requested by the neutral evaluator that were not provided by the parties.

45. Referral to Arbitration

45.1 If any of the issues referred to neutral evaluation were not settled, the issues remaining in dispute will be referred to arbitration **2 days** after delivery to the parties of the ***Report of the Neutral Evaluator.***

45.2 The Director will promptly appoint an arbitrator.

45.3 The neutral evaluator will not preside at the arbitration hearing.

45.4 **Rules 34** and following, apply to an arbitration hearing conducted after neutral evaluation is completed and the parties have not settled the issues in dispute.

46. APPEAL

46.1 A party to an arbitration may appeal an order of an arbitrator to the Director only on a question of law.

46.2 A party may not appeal a preliminary or interim order of an arbitrator until all of the issues in dispute in the arbitration have been finally decided, unless the Director orders otherwise.

46.3 An appeal does not stop an arbitration order from taking effect, unless the Director orders otherwise.

47. STARTING AN APPEAL

47.1 To appeal an arbitration order, the appellant must:

(a) complete a ***Notice of Appeal*** in **FORM H;**

(b) serve a copy of the ***Notice of Appeal*** on the respondent's lawyer or if the respondent was not represented by a lawyer at the arbitration hearing, on the respondent;

(c) file the ***Notice of Appeal*** and a ***Statement of Service*** in **FORM E;** and

(d) pay the application filing fee set out in **Section D** of the Code.

47.2 An appeal may be rejected if:

(a) it does not raise a question of law;

(b) it is from a preliminary or interim order that does not finally decide the issues in dispute;

(c) the ***Notice of Appeal*** is incomplete or lacks sufficient details to allow the other party to respond; or

(d) the appellant does not pay the required application filing fee.

47.3 Upon receiving a properly completed ***Notice of Appeal, Statement of Service*** and the application filing fee, the Commission will promptly acknowledge the appeal.

48. Time For Appeal

48.1 Subject to **Rule 48.2,** the appellant must file the ***Notice of Appeal*** **within 30 days** of the date of the arbitration order.

48.2 The Director may extend the time for requesting an appeal on such terms as he or she considers appropriate, either before or after the 30-day time limit, if he or she is satisfied there are reasonable grounds for granting the extension.

49. Response to Appeal

49.1 **Within 20 days** of receiving the Commission's acknowledgement of the appeal (see **Rule 47.3**), a respondent must:

(a) complete a ***Response to Appeal*** in **FORM I;**

(b) serve the ***Response*** on the appellant's representative or if not represented, on the appellant; and

(c) file a copy of the ***Response*** and a ***Statement of Service*** in **FORM E.**

50. Reply by the Appellant

50.1 **Within 10 days** of being served with a ***Response to Appeal,*** the appellant may reply by:

(a) completing a ***Reply by the Appellant*** in **FORM J;**

(b) serving the ***Reply*** on the respondent's representative or if not represented, on the respondent; and

(c) filing a copy of the ***Reply*** and a ***Statement of Service*** in **FORM E.**

51. Written Submissions

51.1 Unless the Director orders otherwise, the appellant must:

(a) serve and file written submissions **within 30 days** of the date on which the ***Reply by the Appellant*** was due, or would have been due if the Respondent had filed a ***Response to Appeal;*** and

(b) file a ***Statement of Service*** in **FORM E.**

51.2 If a transcript has been ordered, the time limit for the appellant's written submissions set out in **Rule 51.1(a)** is extended to **30 days** from the date on which the transcript is received.

51.3 **Within 20 days** of receiving the appellant's written submissions, the respondent must:

(a) serve on the appellant and any other parties any written submissions upon which the respondent intends to rely; and

(b) file the written submissions and a ***Statement of Service*** in **FORM E.**

52. Appeal by Respondent ("Cross-appeal")

52.1 If the respondent intends to appeal the arbitration order, a separate ***Notice of Appeal*** must be completed and the time periods for appeals, as set out above, apply.

53. The Appeal Process

53.1 The Director may appoint a person to conduct the appeal on his or her behalf and to exercise the powers and perform the duties of the Director relating to the appeal.

53.2 An order made by a person appointed under **Rule 53.1** is considered an order of the Director.

53.3 Unless the Director orders otherwise, an appeal will only include issues that were the subject of the arbitration proceeding or dealt with in the arbitration order being appealed.

53.4 The **appeal record** includes the ***Notice of Appeal,*** the ***Response to Appeal,*** the ***Reply by the Appellant,*** the written submissions of the parties, and the record of the arbitration hearing, including all arbitration exhibits and, if it is filed, the transcript of the arbitration hearing.

53.5 The Director may decide the appeal:

(a) on the record;

(b) by way of an oral hearing or an electronic hearing; or

(c) in any other manner that the Director considers appropriate.

53.6 If the Director decides to schedule an oral or electronic hearing, a **Notice of Hearing** will be delivered to the parties.

54. Preliminary Conference

54.1 The Director may require the parties to participate in one or more preliminary conferences.

54.2 **Rule 33** applies with necessary changes to a preliminary conference held under this Part.

55. Non-participation

55.1 The Director may proceed with an appeal even though a party fails to file any document required by these Rules.

55.2 Where a **Notice of Hearing** has been delivered to a party, and the party does not attend, the Director may proceed with the oral submissions or the hearing in the absence of the party, and the party is not entitled to any further notice of the proceeding.

56. Interventions

56.1 The Director may request persons who are not parties to an appeal to make submissions on any issue of law arising in an appeal, and participation will be on such terms as the Director considers appropriate.

56.2 Persons who are not parties to an appeal may apply to make submissions on an issue of law arising in an appeal.

56.3 A person who wishes to make submissions on an issue of law arising in an appeal must:

(a) complete an ***Application for Intervention*** in **FORM K;**

(b) serve a copy of the ***Application*** on the representative of each of the parties to the appeal or, if a party is not represented, on the party; and

(c) file the ***Application*** and a ***Statement of Service*** in **FORM E.**

56.4 An ***Application for Intervention*** may be rejected if it does not include:

(a) the applicant's reasons for wishing to participate; and

(b) a summary of the applicant's submissions on the issues of law.

56.5 **Within 10 days** of receiving an ***Application for Intervention,*** a party may indicate that he or she supports or objects to the intervention by:

(a) filing his or her written comments; and

(b) sending a copy of his or her written comments to the representative of the applicant, or if not represented, to the applicant.

57. The Intervention Process

57.1 **Rules 53, 54 and 55** apply with necessary changes.

58. APPLICATION FOR VARIATION/REVOCATION

58.1 Either the insured person or the insurer may apply to the Director to vary or revoke an arbitration order or an appeal order if:

(a) there has been a material change in the circumstances of the insured;

(b) evidence not available on the arbitration or appeal has become available; or

(c) there is an error in the order.

58.2 A party may not apply to vary or revoke a preliminary or interim order of an adjudicator until all of the issues in dispute in the proceeding have been finally decided, unless the Director orders otherwise.

58.3 A party seeking to have an arbitration order or an appeal order varied or revoked must:

(a) complete an ***Application for Variation/Revocation*** in **FORM L;**

(b) serve a copy of the ***Application*** on the respondent's lawyer or, if not represented by a lawyer, on the respondent;

(c) file the ***Application*** and a ***Statement of Service*** in **FORM E;** and

(d) pay the application filing fee set out in **Section D** of the **Code.**

58.4 The ***Application for Variation/Revocation*** may be rejected if:

(a) it is from a preliminary or interim order that does not finally decide the issues in dispute;

(b) it is incomplete or lacks sufficient details to allow the other party to respond;

(c) it is in respect of an order that has been appealed, and the appeal is pending; or

(d) the applicant does not pay the required application filing fee.

58.5 The Commission will promptly acknowledge the ***Application for Variation/Revocation*** upon receipt of a properly completed ***Application, Statement of Service*** and the application filing fee.

59. Response to the Application for Variation/Revocation

59.1 **Within 20 days** of receiving the Commission's acknowledgement of the ***Application for Variation/Revocation*** (see **Rule 58.5**), a respondent must:

(a) complete a ***Response to the Application for Variation/Revocation*** in **FORM M;**

(b) serve the ***Response*** on the applicant's representative or if not represented, on the applicant; and

(c) file a copy of the ***Response*** and a ***Statement of Service*** in **FORM E.**

60. Reply by the Applicant in a Variation/Revocation

60.1 **Within 10 days** of being served with a ***Response in the Application for Variation/ Revocation,*** the applicant may reply by:

(a) completing a ***Reply by the Applicant in a Variation/Revocation*** in **FORM N;**

(b) serving the ***Reply*** on the respondent's representative or, if not represented, on the respondent; and

(c) filing a copy of the ***Reply*** and a ***Statement of Service*** in **FORM E.**

61. The Variation/Revocation Process

61.1 The Director may:

(a) decide the ***Application for Variation/Revocation;***

(b) appoint a person to decide the ***Application for Variation/Revocation*** on his or her behalf and to exercise the powers and perform the duties of the Director in relation to the ***Application;*** or

(c) appoint the same adjudicator who made the order or another adjudicator to decide the ***Application for Variation/Revocation***.

61.2 **Rules 51, 53, 54 and 55** apply to an ***Application for Variation/Revocation*** with necessary changes.

62. APPLICABILITY OF THIS PART

62.1 This Part applies to all arbitrations, appeals, interventions and variation/revocation proceedings.

63. ORDERS

63.1 The adjudicator will determine the issues before him or her by order and may make an order subject to such terms as he or she considers just.

63.2 The Commission will deliver a copy of the order and the adjudicator's written reasons, if any, to the parties.

63.3 Any order which finally decides the issues in dispute will be in writing with reasons.

63.4 An adjudicator may, at any time, correct a typographical error, error of calculation or similar error made in his or her order.

63.5 An adjudicator may make such orders or give such directions as he or she considers proper to prevent an abuse of the process.

63.6 An adjudicator may exclude from a hearing anyone, other than a duly qualified barrister and solicitor, appearing as an agent on behalf of a party if the adjudicator finds that the agent is not competent to properly represent the party or does not understand and comply with the duties and responsibilities of an advocate or adviser.

64. ENFORCEMENT OF ORDERS

64.1 On written request, the Commission will provide a party with a certified copy of any order.

64.2 A party may file a certified copy of any order in the Ontario Court (General Division) and the order shall be enforced as if it were a Court order.

64.3 A party who files an order under **Rule 64.2** shall notify the Commission **within 10 days** after the filing.

65. Orders within Proceedings: Motions

65.1 An adjudicator may make preliminary or interim orders within a proceeding, pending a final order.

65.2 A party may request a preliminary or interim order, at any stage within a proceeding, pending a final order.

65.3 A party making such a request must, in writing:

(a) describe the order being sought, the grounds for the order, and provide any documents to be relied on; and

(b) serve this material on the parties and file it.

65.4 **Within 10 days** of being served, the responding party must:

(a) serve the parties with a written response and documents to be relied on; and

(b) file a copy of the written response and documents.

65.5 The adjudicator may determine the request on the basis of the documents and written submissions filed, or in such manner as the adjudicator considers appropriate.

65.6 A request for an interim order or an order on a preliminary issue may also be made orally during a pre-hearing discussion, a preliminary conference, or at a hearing, and will be dealt with in such manner as the adjudicator considers appropriate.

66. Settlement

66.1 The parties may settle any or all issues in dispute at any time. If the parties notify the Commission in writing that the entire matter is settled, the Commission will close its file.

66.2 Either party may request an adjudicator to issue an order dismissing the proceeding on consent of the parties, upon filing:

(a) a consent, signed by the parties or their representatives, stating that they consent to the dismissal of the arbitration and confirming that no party to the proceeding is under a disability;

(b) the terms of any settlement reached by the parties with an acknowledgement by the parties that they have reviewed and complied with the provisions of the ***Regulation*** governing settlement, found in **Section E** of the Code;

(c) the written agreement of the parties that the consent order is final and shall not be subject to appeal, variation/revocation, or judicial review; and

(d) sufficient copies of the consent order, approved as to form and content by the parties, for delivery by the Commission.

67. WITHDRAWAL

67.1 A party may seek permission to withdraw all or part of a dispute:

(a) in writing by serving on the parties a request to withdraw and by filing the request to withdraw together with a ***Statement of Service*** in **FORM E;** OR

(b) orally during a neutral evaluation, pre-hearing discussion, a preliminary conference or at a hearing.

67.2 The Commission or an adjudicator, as the case may be, will permit a party to withdraw if the other parties agree.

67.3 Where a party does not agree to the withdrawal, an adjudicator may:

(a) permit the withdrawal on such terms and conditions as the adjudicator considers appropriate;

(b) award expenses to either party as permitted by **Rules 73** and following, and the **Expense Regulation** under **Section F** of the Code;

(c) award an amount to the insurer, up to the amount the insurer is required to pay to participate in the hearing, if the adjudicator decides an abuse of process has occurred or the proceeding is frivolous or vexatious.

68. Inability to Complete a Hearing

68.1 If an adjudicator becomes unable, for any reason, to complete a hearing or issue an order, the matter may be reheard by a new adjudicator appointed by the Director.

69. Adjournments

69.1 A request for an adjournment of an arbitration must be made in writing to the Registrar; for an adjournment of an appeal, intervention or variation/revocation, the request must be made in writing to the Director. The request must:

(a) outline the reasons for the adjournment;

(b) indicate whether the other parties consent to the adjournment; and

(c) provide alternative hearing dates that are acceptable to all parties.

69.2 A request for an adjournment must be served on the other parties and filed **seven days** in advance of the hearing or in such lesser period of time as the Registrar or Director may permit.

69.3 In deciding whether an adjournment of an arbitration is appropriate, the Registrar shall refer to **Practice Note 8,** "Adjournments", found in **Section C** of the Code.

69.4 An adjudicator may adjourn a hearing on his or her own initiative, or at the request of a party, on such terms he or she considers appropriate.

70. Language Services

70.1 A person has the right to communicate in French, and to receive services in French from the Commission as provided in the *French Language Services Act*.

70.2 An adjudicator may require interpretation services in any other language at a proceeding, at the cost of the Commission.

70.3 Where interpretation services are provided, the interpreter must make an oath or affirm that he or she will truly and faithfully translate the evidence.

71. Summons to Witness

71.1 The adjudicator may, by ***Summons to Witness,*** require a person to:

(a) attend at or participate in a hearing, and to give evidence on oath or otherwise; and

(b) produce in evidence documents and things set out in the summons.

71.2 A ***Summons to Witness*** must be prepared in **FORM O.**

71.3 The party requesting the summons must:

(a) ensure that the ***Summons to Witness*** is served personally on the person summoned **not less than 5 days** before the first day of the hearing, or within such shorter time period as the adjudicator considers appropriate;

(b) pay the person summoned the same fees or allowances as are paid to a person summoned to attend before the Ontario Court (General Division); and

(c) file an ***Affidavit of Service for a Summons*** in **FORM P** as proof that the ***Summons*** was properly served and that the required fees or allowances have been paid. See **Practice Note 7** found in **Section C** of the Code.

72. Transcripts

72.1 Where a party hires a reporting service to transcribe the proceedings, the party must:

(a) inform the other parties and the adjudicator;

(b) make the necessary arrangements for the reporting service; and

(c) directly pay the person or agency providing the reporting service.

72.2 Where a party orders all or a portion of the transcript, the party must:

(a) inform the other parties and the adjudicator;

(b) provide a copy of the transcript to the adjudicator; and

(c) directly pay the person or agency providing the transcript.

73. Award of Expenses

73.1 An adjudicator may award expenses to a party if the adjudicator is satisfied that the award is justified having regard to the criteria set out in **Rule 73.2.** The items and amounts which may be awarded are found in **Rule 76** and the Schedule to the **Expense Regulation** found in **Section F** of the Code.

73.2 The adjudicator will consider the criteria referred to in the **Expense Regulation** found in **Section F** of the Code. These criteria are:

(a) each party's degree of success in the outcome of the proceeding;

(b) conduct of the insurer or the insured person that tended to shorten or facilitate the proceeding or that tended to prolong, obstruct or hinder the proceeding, including failure to comply with undertakings or orders;

(c) whether the proceeding or any position taken by the insurer or the insured person during the proceeding was manifestly unfounded, frivolous, vexatious, fraudulent or an abuse of process;

(d) the degree of complexity, novelty or significance of the factual or legal issues raised in the proceeding;

(e) at the request of either party, any written offer to settle made in accordance with **Rules 74 and 75,** having regard to the outcome of the proceeding;

(f) any other matter related to the proceeding that the adjudicator considers relevant to the issue of whether an award of expenses is justified.

74. Offer to Settle

74.1 An adjudicator will consider an **Offer to Settle** in connection with an award of expenses provided that:

(a) it was made in writing, was served on the other parties and contains:

(i) the full terms of the **Offer to Settle;**

(ii) the date when the **Offer** was served and the time period during which it remained open for acceptance;

AND

(b) the **Offer** was made after the conclusion of mediation and before the conclusion of the hearing, with particular consideration given to any

Offer served after the conclusion of the pre-hearing discussion or preliminary conference as the case may be, up to **five days** before the commencement of the hearing.

74.2 A **Response to an Offer to Settle** will be considered provided that:

(a) it was made in writing, indicates the **Offer** to which it relates; and

(b) it was served upon the other parties before the conclusion of the hearing.

74.3 **An Offer to Settle** or **Response to an Offer to Settle** may be withdrawn at any time before it is accepted, by serving written notice of the withdrawal on the party to whom the offer or response was made.

74.4 An **Offer** or **Response** will expire on the earlier of the expiry date stated in the **Offer** or **Response,** or at the conclusion of the hearing.

74.5 Acceptance of an **Offer** or **Response** must be made in writing and served upon the party making the **Offer** or **Response,** prior to the withdrawal or expiry of the offer.

75. Communication of an Offer to Settle or Response to an Offer to Settle

75.1 When no party to an adjudication seeks to have an **Offer to Settle** or a **Response to an Offer to Settle** considered by the adjudicator in connection with an award of expenses:

(a) the parties will jointly inform the adjudicator of that fact at the conclusion of the hearing; and

(b) Rule 75.2 will not apply.

75.2 In connection with an award of expenses, the parties will not advise the adjudicator of an **Offer to Settle** or a **Response to an Offer to Settle** except as provided in this **Rule:**

(a) the adjudicator will deliver confirmation to the parties that all issues in dispute have been decided, except expenses;

(b) **within 5 days** of the delivery of such confirmation, either party will file any relevant **Offer to Settle** which was made in accordance with **Rule 74.1,** for consideration in connection with an award of expenses provided that:

(i) notice of intention to rely on an **Offer to Settle** is served on the other party along with a copy of the **Offer;** and

(ii) such notice and copy of the **Offer** are filed, together with **Statement of Service** in **Form E**.

(c) **within 5 days** of the service of the notice of intention to rely on an **Offer to Settle** in accordance with **Rule 75.1(b),** a party may file any relevant **Response to an Offer to Settle** which was made in accordance with **Rule 74.2,** for consideration in connection with an award of expenses provided that:

(i) notice of intention to rely on a **Response to an Offer to Settle** is served on the other party along with a copy of the **Response;** and

(ii) such notice and copy of the **Response** are filed, together with **Statement of Service** in **Form E**.

76. Expenses of Representatives (also see Schedule to Expense Regulation found in Section F of the Code)

76.1 The maximum amount that may be awarded to an insured person or an insurer for legal fees is an amount calculated using:

(a) the hourly rates established under the *Legal Aid Act* for professional services in civil matters before the Ontario Court (General Division); or

(b) the hourly rate referred to in **Rule 76.1(a)** adjusted to include, where appropriate, the experience allowance established under the *Legal Aid Act;*

however, where an adjudicator is satisfied that a higher amount for legal fees to an insured person is justified, an hourly rate of up to $150 may be awarded.

76.2 The maximum amount that may be awarded to an insured person or an insurer for agent's fees is an amount calculated using the hourly rates established under the *Legal Aid Act* for law clerks, articling students and investigators.

77. Assessment of Expenses

77.1 Where expenses are awarded, and the parties cannot agree on the amounts to be paid, a party may request an assessment of expenses, as follows:

(a) **within 30 days** from the date of the decision awarding expenses, the party awarded expenses must provide the other party with an account describing each of the expenses claimed, services received and the costs;

(b) the party paying expenses must promptly provide the other party with a written response to the account, identifying the items in dispute and the reasons for the dispute;

(c) the party awarded expenses must promptly provide the other party with copies of supporting documentation, such as invoices, receipts, computerized dockets or cancelled cheques;

(d) if a dispute remains, the parties shall file the above materials, together with a written request for an **assessment of expenses;**

(e) the Commission shall notify the parties whether the assessment will be conducted by way of written submissions, an oral or electronic hearing, and shall notify the parties of the date, time and if necessary, the location of the assessment hearing;

(f) neither party shall be charged a fee for an **assessment of expenses**.

78. Constitutional Question and/or Charter Issue

78.1 Where required by the *Courts of Justice Act,* a party who intends to raise a constitutional question shall serve notice of the constitutional question on the other parties and on the Attorney General of Canada and the Attorney General of Ontario **at least 15 days** before the day on which the question is to be heard by the adjudicator.

78.2 The notice referred to in **Rule 78.1** must clearly set out the reasons for the question and any evidence that the party intends to rely on must be attached to the notice.

78.3 The Attorney General of Canada and the Attorney General of Ontario may intervene in the proceeding.

78.4 A constitutional question refers to the following circumstances:

(a) the constitutional validity or constitutional applicability of legislation, of a regulation or by-law made under legislation, or of a rule of common law, is in question;

(b) a remedy is claimed under subsection 24(1) of the *Canadian Charter of Rights and Freedoms,* in relation to an act or omission of the Government of Ontario.

79. Waiver of Procedural Requirements

79.1 Subject to the requirements of the *Insurance Act* and the *SPPA,* the adjudicator may on such terms as he or she considers appropriate:

(a) set aside any time limit set out in these Rules for doing any act, serving any notice, filing any document or holding any hearing;

(b) decide that any Rule does not apply in respect of a proceeding.

79.2 Any procedural requirement set out in the *Insurance Act* or the *SPPA*, as amended, that applies to a hearing held under these Rules may be set aside with the agreement of the parties and the adjudicator.

80. Testimony and Civil Proceedings

Except with the consent of the Commissioner of Insurance, no adjudicator shall be required to testify in a civil proceeding, in a proceeding before the Commissioner or in a proceeding before any other tribunal respecting information obtained in the discharge of his or her duties.

SECTION B

COMMISSIONER'S GUIDELINES

August 1, 1995

Guideline for Identifying Self-employed Individuals

This guideline is issued pursuant to Section 268.3 of the *Insurance Act.*

This guideline applies to all accidents occurring on or after January 1, 1994, including accidents on or after November 1, 1996, and should be used when it has already been established that the individual is employed, but it is unclear whether the individual is self-employed or what the relationship is between the individual and an employer. Under the *Statutory Accident Benefits Schedule (SABS)* self-employment income is treated differently than employment income.

For the purposes of the SABS, an individual is considered to be self-employed if the business he or she derives his or her remuneration from is not incorporated under any law. For example, sole proprietorships and partnerships are considered to be self-employment situations. If the individual derives his or her remuneration from an incorporated business, then he or she is considered to be an employee of the corporation.

Definitions

Business	An activity that is carried on for profit or with a reasonable expectation of profit, including a profession, a calling, a trade, a manufacture or undertaking of any kind, an adventure or concern in the nature of trade, or a service.
Employee	An individual who is hired to perform pre-determined tasks/work in a business in exchange for remuneration.
Employer	An entity, such as a corporation, group of individuals or a single individual, who hires another individual(s) to perform pre-determined tasks/work in a business in exchange for remuneration.
Purchaser	An entity, such as a corporation, group of individuals or a single individual, that enters into an agreement or contract for service(s) with another individual in exchange for a negotiated remuneration.

The following sets out indicators of self-employment in two situations:

1. TRADITIONAL SELF-EMPLOYMENT SITUATION

The Individual:

- is an owner of an unincorporated sole proprietorship or a partner in a partnership (other than a limited partner).
- has an established location where business transactions take place.
- participates in the everyday operations of the business (not just an investor or receiving remuneration for purposes of income splitting).
- determines own method and schedule for accomplishing tasks.
- determines own hours and may not necessarily work a set number of hours per period (i.e. 40 hour week).
- negotiates the price(s) of product(s) or fee(s) for service(s) with the customer or client with the exception of regulated fields (i.e. physicians).
- determines the annual income as his or her profit from the business according to the *Income Tax Act (Canada)* and *Income Tax Act (Ontario).*
- is ineligible for regular Employment Insurance benefits.
- contributes the employer and employee contributions to Canada Pension Plan (CPP) for his or her own pension plan.
- collects and remits all taxes to different levels of government according to each respective tax legislation (i.e. GST, PST, source deductions from employee(s)).

In the case of a sole proprietorship:

- has control over:
  (1) the hiring and dismissal of employee(s),
  (2) the wage level and hours of work of employee(s),
  (3) the method by which employee(s) accomplish work, and
  (4) executive decisions surrounding the business.

In the case of a partnership:

- has some or all control, depending on agreements with his or her partner(s) over:
  (1) the hiring and dismissal of employee(s),
  (2) the wage level and hours of work of employee(s),
  (3) the method by which employee(s) accomplish work, and
  (4) executive decisions surrounding the business.

Examples: (1) owner/operator or partner of a restaurant, convenience store, etc.
(2) physician in private practice

2. CONTRACT OF SERVICE SITUATION

The Individual:

- has contract work with no long-term or permanent relationship to a specific purchaser.
- is providing the actual service(s) which may be performed at one or more locations for one or more purchasers over the same period of time.
- determines own method and schedule for accomplishing tasks.
- determines own hours and may not necessarily work a set number of hours per period (i.e. 40 hour week).
- negotiates fees for services provided to the purchaser.
- has a business-relationship with a purchaser(s) evidenced by a contract or agreement, either written or oral, express or implied, usually providing some sort of labour.
- does not hire any employees.
- is ineligible for regular Employment Insurance benefits.
- contributes the employer and employee contributions to CPP for his or her own pension plan.

- determines the annual income as his or her profit from the business according to the *Income Tax Act (Canada)* and *Income Tax Act (Ontario)*.

Examples:
1) Independent cleaners
2) Independent truck driver
3) Handyman
4) Limousine driver

Guideline for Statutory Accident Benefits Applications, the Claims Process and the Mediation Process (Bill 59)

This guideline is issued pursuant to Section 268.3 of the *Insurance Act*.

This guideline applies to accidents occurring on or after November 1, 1996. The purpose of this guideline is to help insurers and claimants understand their rights and responsibilities when dealing with statutory accident benefit claims. Above all else there is an obligation on both insurers and insured persons (referred to as "claimants" in this guideline) to act fairly with each other in making an application for benefits and in processing claims.

The full and timely exchange of information by both insurers and claimants is critical. Insurers must limit their requests to information that is related to the claim and claimants must give an insurer the information that the company needs to establish the nature, extent and continuing validity of a claim. Claimants must not withhold any information, delay, make the insurer's evaluation of the claim more difficult or impossible.

Claimants should realize that unreasonable actions will delay payments and can lead to denial of benefits without access to court or arbitration. Insurers can also terminate benefits if a claimant wilfully misrepresents facts with respect to an application for accident benefits.

Insurers should realize that unreasonable actions are treated as unfair practices and may lead to penalties under Section 282(10) of the *Insurance Act,* cease and desist orders and prosecution.

This guideline applies equally to all insurers, claimants and their representatives and is to be considered in any decision involving the interpretation of the *Statutory Accident Benefits Schedule (SABS).* The details of the rights and responsibilities of the parties are set out in the sections called "Principles For Statutory Accident Benefits Applications And The Claims Process" and "Principles For The Mediation Process".

PRINCIPLES FOR STATUTORY ACCIDENT BENEFITS APPLICATIONS AND THE CLAIMS PROCESS

Insurers' Responsibilities

- Inform claimants about the kind of accident benefits that are available under the *SABS,* let claimants know all the procedures to be followed and documentation needed when applying for benefits. When asked, insurers must give a copy of the *SABS* without charge to any person entitled to benefits.

- Give claimants the application for benefits package and other applicable forms, and help claimants complete all forms.

- Provide claimants with specific requests for additional relevant information.

- Make sure that all requests for information from claimants and third parties are relevant to the claimant's entitlement to benefits.

- Evaluate all applications for benefits fairly and quickly.

- Let claimants know about all decisions made concerning their claim within the times specified in the *SABS,* give the reasons for those decisions, and make sure that payments due to claimants are made within the times specified in the *SABS.*

- Pay for reasonable measures to reduce or eliminate the effects of any disability resulting from injuries sustained by a claimant in an accident and to help their reintegration into their family, the labour market and the rest of society.

- Cooperate with representatives retained or appointed by claimants to help claimants with their claims.

- Make sure notices to claimants are in writing and in plain language.

- Make sure requests for a claimant to undergo an assessment or examination are to obtain necessary information.

- Make sure assessors or evaluators who are asked by the insurer to examine a claimant accommodate the claimant when scheduling appointments to minimize inconvenience to the claimant.

Claimants' Responsibilities

- Complete all forms promptly. The *SABS* require that applications for accident benefits be submitted within 30 days of receiving the forms from the insurer.

- Give their insurer all reasonably relevant information requested by the insurer to prove their entitlement to benefits including a statutory declaration as to the circumstances that gave rise to the accident benefits application.

- Give true and accurate information.

- Give third parties the right to release information about the claimant needed by insurers to evaluate the claim for benefits.

- Submit a treatment plan before incurring medical or rehabilitation expenses.

- Take part in treatment and rehabilitation that will allow them to start or return to work, or shorten their period of disability.

- Cooperate with representatives retained or appointed to help insurers evaluate claims.

- Promptly let their insurer know about any material change in their circumstances affecting their entitlement to benefits (the *Insurance Act* requires that this be done within 14 days).

- Take part in assessments or examinations that their insurer is allowed to ask for under the *SABS* including those done by designated assessment centres (DACs).

- Give notice (under normal circumstances, notice should be given within 2 days) to their insurer and the assessor or examiner when they cannot attend a scheduled appointment and give reasons why they cannot attend.

- Give any person allowed to examine or assess the claimant under the *SABS,* the information that is reasonably necessary to do the examination and allow third parties to also give out such information.

- Agree to have reports produced by persons allowed to examine the claimant under the *SABS* given to your insurer.

PRINCIPLES FOR THE MEDIATION PROCESS

A) Responsibilities of claimants wishing to apply for mediation services

- have previously completed an application for benefits and all forms in full and submitted them to your insurer; and

- take part in any assessment or examination required under the *SABS,* and give the assessor any information needed for an assessment under the *SABS.*

B) Responsibilities of insurers and claimants before using mediation services at the Ontario Insurance Commission

- clarify the facts;

- identify the issues in dispute according to both of them;

- discuss and arrange for the timely exchange of relevant documents; and

- make reasonable efforts towards reaching a settlement.

C) Other responsibilities of claimants

- personally take part and cooperate in the mediation process.

Guideline for Statutory Accident Benefits Applications, the Claims Process and the Mediation Process

This Guideline is issued pursuant to Section 268.3 of the *Insurance Act.*

The purpose of this Guideline is to help insurers and claimants understand their rights and responsibilities when dealing with statutory accident benefit claims. Above all else there is an obligation on both insurers and insured persons (referred to as "claimants" in this guideline) to act fairly with each other in making an application for benefits and in processing claims. The full and timely exchange of information by both insurers and claimants is critical.

However, insurers must limit their requests to information that is related to the claim. Likewise, claimants must give an insurer the information that the company needs to establish the nature, extent and continuing validity of a claim. Claimants must not withhold any information, delay, make more difficult or impossible the insurer's evaluation of the claim. Set out in the sections called "Principles For Statutory Accident Benefits Applications And The Claims Process" and "Principles For The Mediation Process" are the details of the rights and responsibilities of the parties. This Guideline applies equally to all insurers, claimants and their representatives and is to be considered in any decision involving the interpretation of the *Statutory Accident Benefits Schedule (SABS).*

Claimants should realize that unreasonable actions will delay payments and can lead to denial of benefits without access to court or arbitration.

Insurers should realize that unreasonable actions are treated as unfair practices and may lead to penalties under Section 282(10) of the *Insurance Act.*

*This guideline applies to Bill 164-Accidents After December 31,1993 and Before November 1, 1996, as per OIC Bulletin No. A-12/96.

PRINCIPLES FOR STATUTORY ACCIDENT BENEFITS APPLICATIONS AND THE CLAIMS PROCESS

Insurers' Responsibilities

- Inform claimants about the kind of accident benefits that are available under the *SABS,* let claimants know all the procedures to be followed and documentation needed when applying for benefits. When asked, insurers must give a copy of the *SABS* without charge to any person entitled to benefits.
- Give claimants the application for benefits package and other applicable forms, and help claimants complete all forms.
- Provide claimants with specific requests for additional relevant information.
- Make sure that all requests for information from claimants and third parties are relevant to the claimant's entitlement to benefits.
- Evaluate all applications for benefits fairly and quickly.
- Let claimants know about all decisions made concerning their claim within the times specified in the *SABS,* give the reasons for those decisions, and make sure that payments due to claimants are made within the times specified in the *SABS.*
- Pay for reasonable measures to reduce or eliminate the effects of any disability resulting from injuries sustained by a claimant in an accident and to help their reintegration into their family, the labour market and the rest of society.
- Cooperate with representatives retained or appointed by claimants to help claimants with their claims.
- Make sure notices to claimants are in writing and in plain language.
- Make sure requests for a claimant to undergo an assessment or examination are to obtain necessary information.

- Make sure assessors or evaluators who are asked by the insurer to examine a claimant accommodate the claimant when scheduling appointments to minimize inconvenience to the claimant.

Claimants' Responsibilities

- Complete all forms promptly.
- Give their insurer all reasonable relevant information asked for by the insurer to prove their entitlement to benefits.
- Give true and accurate information.
- Give third parties the right to release information about them needed by insurers to evaluate their claim for benefits.
- Take part in treatment and rehabilitation that will allow them to start or return to work, or shorten their period of disability.
- Cooperate with representatives retained or appointed to help insurers evaluate claims.
- Promptly let their insurer know about any change in their situation affecting their entitlement to benefits (under normal circumstances, this should be done within 14 days).
- Take part in assessments or examinations that their insurer is allowed to ask for under the *SABS* including those done by designated assessment centres (DACs).
- Give notice (under normal circumstances, notice should be given within 2 days) to their insurer and the assessor or examiner when they cannot attend a scheduled appointment and give reasons why they cannot attend.
- Give any person allowed to examine or assess the claimant under the *SABS,* the information that is reasonably necessary to do the examination and allow third parties to also give out such information.
- Agree to have reports produced by persons allowed to examine the claimant under the *SABS* given to their insurer.

PRINCIPLES FOR THE MEDIATION PROCESS

A) Responsibilities of claimants wanting to apply for mediation services

- completed an application for benefits and all forms in full; and
- take part in any assessment or examination required under the *SABS,* and give the information needed for an assessment under the *SABS.*

B) Responsibilities of insurers and claimants before using mediation services at the Ontario Insurance Commission

- clarify the facts;
- identify the issues in dispute according to both of them;
- discuss and arrange for the timely exchange of relevant documents; and
- make reasonable efforts towards reaching a settlement.

C) Other responsibilities of claimants

- personally take part in the mediation process.

Guideline for Selecting the Nearest Designated Assessment Centre

This Guideline is issued pursuant to Section 268.3 of the *Insurance Act.*

The purpose of this Guideline is to assist insurers and claimants in arranging assessments at designated assessment centres (DACs) at the earliest convenient time and to resolve operational and interpretive issues concerning the selection of a DAC that is nearest to the residence of an insured person.

Sections 39, 45, 50, and 64 of the *Statutory Accident Benefits Schedule (SABS)* provides that where an assessment is requested, it is conducted by the DAC "nearest to the residence of the insured person" that is authorized to assess impairments of the type sustained by the insured person.

It is expected that the DAC will promptly arrange for the assessment. The Guidelines for Designated Medical and Rehabilitation Assessment Centres, Guidelines for Designated Disability Assessment Centres, and Guidelines for Designated Attendant Services Assessment Centres established by the Accident Benefits Advisory Committee set out a time frame of 14 days for the intake phase of the assessment process once the complete referral package is received. This phase includes setting up appointments with the assessor(s). This standard was established to ensure that insurers and claimants are provided with opinions regarding disability or treatment and services as quickly as possible.

However, DACs may not always be able to accommodate referrals within the 14-day time frames established by the Accident Benefits Advisory Committee because of volume, staff vacations and other commitments. In these instances, insurers and insured persons should interpret the *SABS* as requiring the assessment to be conducted by the DAC next closest to the claimant's residence that can accommodate the parties within 14 days of receiving the complete referral.

Where a DAC is unable to meet the 14-day time frame, it should advise the insurer arranging the DAC assessment and confirm this in writing, in order to allow the next nearest DAC to be notified without delay.

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*This guideline applies to Bill 164-Accidents After December 31,1993 and Before November 1, 1996, as per OIC Bulletin No. A-12/96.

Guideline for Identifying Students Who Qualify for The Student Non-Earner Benefit (Bill 59)

This guideline is issued pursuant to Section 268.3 of the Insurance Act.

This guideline applies to accidents occurring on or after November 1, 1996 and is to be considered when determining whether an insured person qualifies for the non-earner benefit as a student or as someone who has recently completed his or her education at the time of the accident.

For the purposes of the *Statutory Accident Benefits Schedule (SABS),* an individual may qualify for non-earner benefits if he or she, at the time of an accident:

1. was enrolled on a full-time basis in elementary education;
2. was enrolled on a full-time basis in secondary education;
3. was enrolled on a full-time basis in post-secondary education;
4. completed his or her education within one year prior to the accident.

Elementary education	includes kindergarten to grade eight at a public school, separate school or private school of equivalent level, approved by the minister responsible for education or comparable education level in other jurisdictions approved by a comparable authority.
Secondary education	includes grades nine to thirteen or equivalent, at a school that is under the jurisdiction of a public or separate school board or a private school of equivalent level, approved by the minister responsible for education or comparable education level in other jurisdictions approved by a comparable authority.
Post-secondary education	includes programs taken at community colleges, universities and equivalent institutions approved by the minister responsible for education or education programs taken at institutions in other jurisdictions with approval by a comparable authority.

An individual is eligible for non-earner benefits whether or not the automobile accident occurred at a time when he or she normally attends classes.

Completed Education means the insured person successfully completed his or her schooling or education program he or she was pursuing (elementary, secondary or post secondary) or the insured person withdrew from school with no intention of returning.

Election

In some cases, an individual may be eligible for more than one weekly benefit. In these cases, the person must elect which benefit he or she wishes to receive under Section 36 of the *SABS.*

Guideline for Identifying Individuals Who Qualify for Education Disability Benefits

This guideline is issued pursuant to Section 268.3 of the *Insurance Act.*

This guideline is to be considered when determining whether an insured person qualifies for education disability benefits.

For the purposes of the *Statutory Accident Benefits Schedule (SABS)*, an individual may qualify for education disability benefits if he or she can be described as:

1. pre-school age at the time of the accident and continues to have a disability which causes the child to miss a year of school, or
2. enrolled on a full-time basis in an elementary education level, or
3. enrolled on a full-time basis in a secondary education level, or
4. enrolled on a full-time basis in a post-secondary education level, or
5. completed school within one year prior to the accident.

DEFINITIONS:

Elementary education level	includes kindergarten to grade eight at a public school, separate school or private school of equivalent level, approved by the minister responsible for education or schools in other jurisdictions approved by a comparable authority.
Secondary education level	includes grades nine to thirteen or equivalent, at a school that is under the jurisdiction of a secondary school board or a private school of equivalent level, approved by the minister responsible for education or schools in other jurisdictions approved by a comparable authority.
Post-secondary education level	includes programs taken at community colleges, universities and equivalent institutions approved by the minister responsible for education or programs taken at institutions in other jurisdictions with approval by a comparable authority.

* This guideline applies to Bill 164-Accidents After December 31, 1993 and before November 1, 1996 as per OIC Bulletin No. A-12/96.

TYPICAL SITUATIONS:

1. Pre-School Age

These individuals are normally children under age five on the date of the accident. They do not qualify for education disability benefits at the time of the automobile accident.

The individual would qualify for the lump-sum benefit at the age at which he or she would have started elementary school, provided the impairment sustained in an automobile accident prevents him or her from successfully completing that year.

2. Elementary Education Level

For the purposes of the *SABS,* an individual is eligible for education disability benefits if he or she is enrolled and attending a school providing education at an elementary level.

An individual is also eligible for education disability benefits if the automobile accident occurred at the time a school providing the education does not normally operate.

3. Secondary Education Level

For the purposes of the *SABS,* an individual is eligible for education disability benefits if he or she is enrolled and attending a school providing education at a secondary level.

An individual is also eligible for education disability benefits if the automobile accident occurred at the time a school providing the education does not normally operate.

4. Post-Secondary Education Level

For the purposes of the SABS, an individual is eligible for education disability benefits if he or she is accepted or enrolled in a school providing education at a post-secondary level.

An individual is also eligible for education disability benefits if the automobile accident occurred at a time when he or she does not normally attend classes.

A student who is in a co-operative program and working at the time of the accident is also eligible for education disability benefits.

5. Completed School

An individual qualifies for the weekly education disability benefit if he or she completed his or her education within one year prior to an automobile accident and is not employed or in an employment not reflecting his or her education and training.

An individual who withdraws from school also qualifies for the weekly education benefit if the automobile accident occurred within one year of withdrawing from school.

Election

In some cases, an individual may be eligible for another weekly benefit as well as being eligible for the education disability benefit. In these cases, the election under section 61 applies.

Guideline On The Management Of Claims Involving Whiplash-Associated Disorders

This guideline is issued pursuant to Section 268.3 of the *Insurance Act.*

This guideline applies to all accidents occurring on or after January 1, 1994, including accidents on or after November 1, 1996 and is intended to help insurers, claimants, and providers understand what is a reasonable medical and rehabilitation expense for a person who has sustained a whiplash injury in an auto accident. The *Statutory Accident Benefits Schedule* requires that insurers pay for all reasonable and necessary medical and rehabilitation expenses incurred by or on behalf of a claimant who sustains an impairment as a result of an auto accident.

Background

The Société d'assurance automobile du Québec (SAAQ) is the public auto insurer in the Province of Quebec. The SAAQ sponsored a task force on whiplash-associated disorders (WAD) which submitted a report in early 1995. The Task Force Report makes specific recommendations regarding the prevention, diagnosis and treatment of WAD. Included in the report is a proposal for classifying WAD and patient management guidelines. The *Guideline on the Management of Claims Involving Whiplash-Associated Disorders* is based on the recommendations made by the Quebec Task Force.

For those who would like to review the study, the Task Force Report titled *Redefining "Whiplash" and its Management* was published in the April 15, 1995 edition of *Spine.* The full report is available directly from the SAAQ.

Definitions

The Quebec Task Force defined **whiplash** as an acceleration-deceleration mechanism of energy transfer to the neck which may result from rear-end or side impact, predominantly in motor vehicle collisions, but also from diving accidents, and from other mishaps. The energy transfer may result in bony or soft tissue injuries (whiplash injury), which in turn may lead to a wide variety of clinical manifestations (whiplash-associated disorders).

Whiplash-associated disorder (WAD) is the term adopted by the Quebec Task Force to describe the clinical entities associated with the energy transfer and the injury.

WAD Case Management Guide

Insurers should encourage practitioners to use the *Quebec Classification of Whiplash-Associated Disorders* (found in Chart 1) in their reports.

Chart 2 provides a guide, in the form of a flow chart, to managing WAD cases. Insurers are encouraged to use the chart and accompanying operational definitions. Insurers should be aware that this is only a guide in evaluating the clinical management of their claimants with WAD and only in those cases where no other injury exists. The most important objective is to prevent chronicity. The consensus is that claimants that are disabled for six months or more should be considered chronic.

According to Chart 2, unresolved disability in Grade I WAD cases would undergo a specialized consultation at 3 weeks and a multidisciplinary consultation after 6 weeks. For Grade II and III WAD, specialized consultation for unresolved cases should take place at 6 weeks and multidisciplinary consultation at 12 weeks. Grade I WAD cases with persistent problems should be reassessed in 7 days, and Grade II and III WAD cases, who have not returned to usual activity in 3 weeks, should be reassessed.

Treatment of WAD

The Quebec Task Force found most therapeutic interventions currently used in patients with WAD have not been evaluated in a scientifically rigorous manner. Those treatments that have been evaluated in a scientifically rigorous manner show little evidence of effectiveness. In general, interventions promoting activity such as mobilization, manipulation, and exercises in combination with analgesics or certain anti-inflammatory drugs are effective on a time-limited basis. Insurers should carefully monitor claims where treatment is prolonged and activity is discouraged.

Insurers should be wary of claims where the practitioner is not encouraging early return to usual activities. Immediate return to usual activities is recommended for Grade I WAD with no work restriction. For Grade II and III WAD, return to usual activity as soon as possible should be encouraged, typically in less than 1 week for Grade II WAD. Work modifications may be necessary for Grades II and III, but should be temporary, except for clinical circumstances justified as unusual or for atypical work settings. Work modifications should be reassessed within 3 weeks.

Chart 3 summarizes treatment recommendations made by the Quebec Task Force for WAD patients. Insurers may wish to use the chart as a guide to evaluating treatment programs.

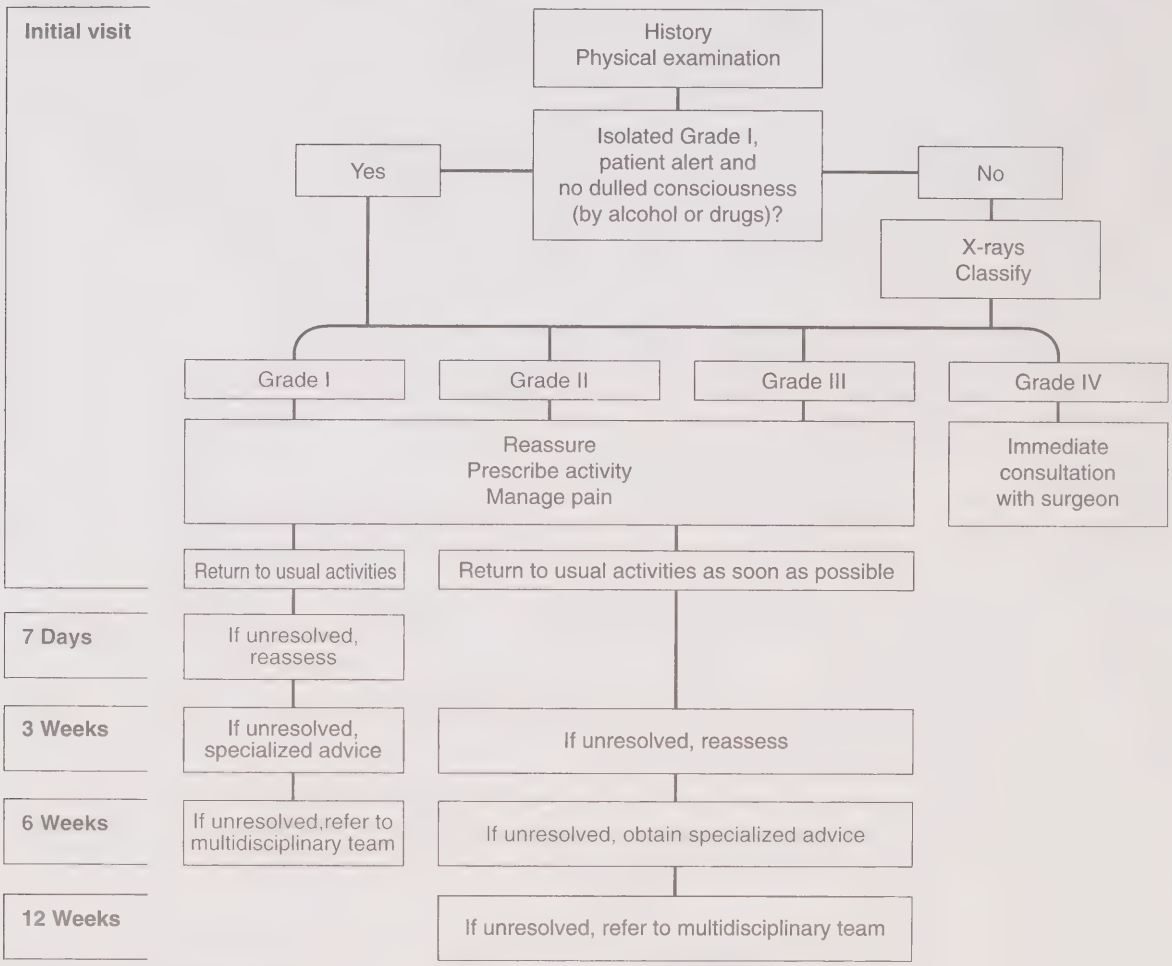
CHART 1:
QUEBEC CLASSIFICATION OF WHIPLASH-ASSOCIATED DISORDERS

Grade	Clinical Presentation
I	Neck complaint of pain, stiffness or tenderness only; No physical sign(s)
II	Neck complaint **AND** Musculoskeletal sign(s) including decreased range of motion and point tenderness
III	Neck complaint **AND** Neurological sign(s) including decreased or absent deep tendon reflexes, weakness and sensory deficits
IV[1]	Neck complaint **AND** Fracture or dislocation

Symptoms and disorders that can be manifest in all grades include deafness, dizziness, tinnitus, headache, memory loss, dysphagia, and temporo-mandibular joint pain.

[1]Grade IV injuries are not considered WAD.

CHART 2: WAD CASE MANAGEMENT GUIDE



OPERATIONAL DEFINITIONS

Isolated	Not associated with other injuries.
Multidisciplinary team	Health professionals with in-depth formal training in musculoskeletal disorder, psychosocial assessment, and other specialties.
Prescribe activity	Interventions should focus on promoting activity. Range of motion exercises should be implemented. Techniques that promote mobility of the cervical spine can be used but should be applied by qualified personnel. Interventions that impede active mobilization of the neck are not indicated.
Reassure	Patients should be advised that most WAD are benign and self-limiting, and they should be encouraged to resume usual activities of life as soon as possible.
Return to usual activities	Patients should be advised to resume their activities of daily living, as soon as possible (usually immediately for Grade I). It should be explained to patients that usual activities may be temporarily painful but not harmful in WAD.
Specialized advice	Consultations with a health professional with in-depth formal training in managing WAD.
Unresolved	Unable to resume usual activities. A patient who still has residual pain or limitation of range of motion but who is able to resume work and other usual activities is considered to have resolved WAD.

CHART 3: TREATMENT GUIDE FOR WAD

Treatment	Recommendation
IMMOBILIZATION	
Collars:	Collars should not be prescribed for Grade I WAD. If prescribed for Grade II or III, they should be restricted to no more than 72 hours as they may promote inactivity and delay recovery.
Prescribed rest:	Rest should not be prescribed for WAD I. Rest for more than 4 days should not be prescribed for WAD II. Prolonged rest can be detrimental to recovery.
Cervical pillows:	Cervical pillows are not required.
ACTIVATION	
Manipulation:	A short-term regimen of manipulation can be used for WAD. This technique should be restricted to qualified practitioners.
Mobilization:	A regimen of mobilization may be used for WAD.
Exercise:	Range of motion exercises should be implemented immediately, in combination if necessary, with intermittent rest when pain is severe. Clinical judgement is crucial if symptoms are aggravated.
Posture advice:	Postural advice can be given in combination with activation in WAD.
Spray and stretch:	Spray and stretch is not recommended.
Traction:	A regimen of traction can be used in combination with other mobilizing interventions in WAD.

Treatment	Recommendation
PASSIVE MODALITIES/ELECTROTHERAPIES	
Heat, ice, massage, TENS[1], PEMT[2], electrical stimulation, ultrasound, laser, short-wave diathermy:	PEMT is not recommended for Grade I WAD because it involves wearing a soft collar for 8hr/day for 12 weeks. The other professionally administered passive modalities/electrotherapies are optional adjuncts for Grades II and III WAD during the first 3 weeks to activating interventions with emphasis on return as soon as possible to usual activity
SURGICAL TREATMENT	There are no indications for surgical intervention in Grade I and II WAD. Surgery is to be restricted to the rare Grade III WAD with persistent arm pain that does not respond to conservative management or with rapidly progressing neurologic deficit.
INJECTIONS	
Steroid injections:	Intra-articular steroid injection cannot be recommended for WAD. There is no reason for a practitioner to prescribe any of these treatments. Practitioners should recommend against the magnetic necklace. Epidural steroid injections should not be used for Grade I or II WAD. Occasionally, Grade III WAD with unresolved radicular pain of less than 1 month might benefit from epidural steroid injections. There is no indication for steroid trigger point injection in the acute phase (first 3 weeks). Because harmful side effects of repeated steroid use have been reported, steroid trigger point injections should not be used unless their benefit in WAD is shown.
Sterile water injections:	Sterile water subcutaneous trigger point injections can be used for Grade II WAD where trigger points are present as an optional adjunct to activating interventions with emphasis on return to usual activities.

[1] Transcutaneous electrical nerve stimulation.
[2] Pulsed electromagnetic treatment.

Treatment	Recommendation
PHARMACOLOGY	No medication should be prescribed for Grade I WAD. Non-narcotic analgesics and NSAIDs[3] can be used to alleviate pain for short-term in Grades II and III WAD. Their use should not be continued for more than 3 weeks. Narcotic analgesics should not be prescribed for Grade I and II WAD. Occasionally, they may be prescribed for pain relief in acute severe Grade III, but only for a limited period of time. Muscle relaxants should not generally be used in the acute phase of WAD. The psychopharmacologic drugs are not recommended for use on a general basis in WAD but they may be used occasionally for symptoms such as insomnia or tension, as an adjunct to activating interventions during the first 3 months. For chronic pain in WAD (over 3 months duration), the minor tranquillizers and antidepressants may be used.
MISCELLANEOUS INTERVENTIONS (FORMALLY PRESCRIBED)	
Prescribed function, Neck school, work alteration, relaxation techniques, acupuncture:	Prescribed function, i.e., **immediate** return to usual activity, is recommended for Grade I WAD. Neck school, work alteration, and relaxation techniques are not indicated for Grade I WAD. For Grades II and III, prescribed function, i.e., return to usual activity, is encouraged as soon as possible. Neck school, temporary work alteration, relaxation techniques, and acupuncture are optional adjuncts for symptom durations of more than 3 weeks in Grades II and III.
OTHER INTERVENTIONS (NOT FORMALLY PRESCRIBED)	
Magnetic necklace, relaxation techniques, topicals, herbal and homeopathic remedies, over the counter, medication, reflexology	There is no reason for a practitioner to prescribe any of these treatments. Practitioners should recommend against the magnetic necklace.

[3] Nonsteroidal anti-inflammatory drugs such as aspirin or acetaminophen.

Optional Indexation Benefit Guidelines

These guidelines are issued pursuant to section 268.3 of the *Insurance Act* and apply to accidents occurring on or after November 1, 1996.

Purpose

The purpose of the *Optional Indexation Benefit Guidelines* is to set out the procedures and formulas for indexation as referred to in section 29 of the *Statutory Accident Benefits Schedule – Accidents on or After November 1, 1996.*

General Application

These guidelines apply to named insured persons who have purchased the optional indexation benefit, their spouse, dependants and persons specified as drivers under the policy.

Indexation applies to the following benefits and monetary limits:

1) the weekly amount of any income replacement benefit
2) the weekly amount of any non-earner benefit
3) the weekly monetary limits applicable to income replacement benefits
4) the weekly monetary limits applicable to caregiver benefits
5) the monthly attendant care monetary limits
6) the outstanding balance of medical and rehabilitation benefits available
7) the outstanding balance of attendant care benefits available
8) the outstanding balance of medical, rehabilitation and attendant care benefits available to persons who have access to the optional increased medical, rehabilitation and attendant care benefit

Benefit amounts and monetary limits are indexed on January 1 of each year immediately following the accident.

Indexation Percentage

The indexation percentage is the percentage change in the Consumer Price Index for Canada (All Items), as published by Statistics Canada under the authority of the *Statistics Act (Canada)*, for the period from September in the year immediately preceding the previous year to September of the previous year.

The indexation percentage for January 1, 1997 will be published by the Ontario Insurance Commission once it is available.

Indexation of Income Replacement Benefit (IRB) and Non-Earner Benefit

The weekly amount of a person's income replacement benefit (80 per cent of net income) and the applicable monetary limit ($400, $600, $800 or $1,000, depending on whether optional IRBs were purchased), are adjusted using the indexation percentage on January 1 of the year immediately after the accident. In each subsequent year, the weekly benefit and limit from the previous year are adjusted. Indexation is applied before taking into account any collateral source income.

Similarly, with respect to the non-earner benefit, the benefit limits ($185 and $320, as applicable to the person) are adjusted using the indexation percentage on January 1 of the year immediately after the accident. In each subsequent year, the previous year's limit is adjusted. Indexation is applied before taking into account any collateral source income.

Indexation of Weekly Limits for Caregiver Benefit and Monthly Limits for Attendant Care Benefit

The indexation percentage is applied to the monetary limits for the caregiver benefit and the attendant care benefit on January 1 of the year immediately following the accident. In each subsequent year, the limits from the previous year are adjusted.

Indexation shall be performed in accordance with the following formula:

A = B x (1+(C ÷100)) where,

A= the new amount (ie. the new monetary limit or the new weekly benefit)
B= the previous year's amount
C= the indexation percentage

Indexation of Medical, Rehabilitation and Attendant Care Limits

The outstanding balance with respect to medical and rehabilitation benefits and the outstanding balance with respect to the attendant care benefit are indexed on January 1 of each year immediately after the accident. Indexation of these limits is performed using a declining balance method.

Incurred medical, rehabilitation and attendant care expenses up to December 31 of the year are subtracted from the insured person's limits for that year, for each benefit. The indexation percentage is applied to the outstanding balance (i.e. the unused portions). The indexed amounts become the insured person's new monetary limits for the year. Indexation using the declining balance method applies to each of the following:

1) the combined medical and rehabilitation monetary limit,
2) the attendant care monetary limit, and
3) the combined medical, rehabilitation and attendant care monetary limit, if the optional medical, rehabilitation and attendant care benefit was purchased.

Indexation using the declining balance method shall be applied in accordance with the following formula:

A = (B – C) x (1+(D÷100)) where,

A= **the new monetary limit** (ie. new medical and rehabilitation monetary limit, new attendant care monetary limit or new combined monetary limit available to the person)
B= **the previous year's monetary limit**
C= **the sum of all incurred expenses for the previous year** (ie. sum of medical expenses, rehabilitation expenses or attendant care expenses)
D= **the indexation percentage**

Notice of Outstanding Balance

Upon the request of the insured person, insurance companies are to provide a notice stating the outstanding balance, as indexed, of the medical and rehabilitation benefits and the attendant care benefit and the outstanding balance of the combined benefits, if applicable, as of January 1 of the year.

Transportation Expense Guidelines

These guidelines are issued pursuant to section 268.3 of the *Insurance Act* and apply to accidents occurring on or after November 1, 1996.

Purpose

The purpose of the *Transportation Expense Guidelines* is to provide a framework for insurers and insured persons to determine the circumstances under which expenses related to transportation of an insured person to and from treatment sessions must be paid by an insurer. The guidelines set out authorized expenses and applicable rates for the purpose of subsections 14(5), 15(11) and 24(3) of the *Statutory Accident Benefits Schedule – Accidents on or After November 1, 1996.*

Authorized Expenses

The insurer is liable to pay for all reasonable and necessary transportation expenses for each trip that the insured person makes to and from treatment sessions, counselling sessions, training sessions, examinations and assessments. The insurer is also liable to pay for all reasonable and necessary transportation expenses of the insured person's aide or attendant. Transportation expenses are calculated based on the most direct route. Transportation expenses include parking fees incurred.

The mode of transportation selected should be the most economical, practical for the distance to be travelled and appropriate under the specific circumstances.

Use of Automobiles

The insurer is liable to pay a mileage expense for transportation of the insured person and their aide or attendant, to and from treatment sessions, counselling sessions, training sessions, examinations and assessments using the insured person's automobile, excluding the first 50 kilometres of each trip. This applies to minors who are driven to treatment sessions, examinations or assessments.

For the purpose of these guidelines, the "insured person's automobile" includes any automobile owned or leased by the insured person or any other automobile to which the insured person has access.

The rate that is to be used to calculate transportation expenses for the use of the insured person's automobile is twenty two cents per kilometre (22¢/km) travelled.

Use of Taxis

The insurer is liable to pay for reasonable and necessary taxi fare incurred by an insured person and their aide or attendant provided that,

- the insured person does not own or have access to an automobile; or
- the insured person is unable to operate an automobile; or
- it is reasonable and practical in the circumstances to take a taxi.

Other Modes of Transportation

Insurers are liable to pay for reasonable and necessary expenses for other modes of transportation where circumstances warrant. Before an insured person incurs expenses for air, rail and bus transportation services, he or she should discuss the matter with their insurer.

Section C

Practice Notes

Ontario Insurance Commission / Commission des assurances de l'Ontario

PRACTICE NOTE
NOTE PRATIQUE 1

Dispute Resolution Group / Groupe de réglement des differends

THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS

USING MEDICAL EVIDENCE TO SUPPORT YOUR CLAIM FOR ACCIDENT BENEFITS

Claimants are required to prove and support their claim for accident benefits with appropriate medical evidence.

The type of medical documentation you will need to support your claim for accident benefits depends upon when your accident occurred. Changes to the *Statutory Accident Benefits Schedule* ("SABS"), effective November 1, 1996 (Bill 59), include changes to the procedures and documents used to claim benefits. To find out exactly what procedures to use in your case, you should refer to the version of the SABS in effect at the time your accident occurred.

No matter when your accident occurred, medical documentation will generally be required in three situations: starting your claim; continuing your claim and disputing the end of your claim.

This note explains the general procedures for providing the information required to support your claim for benefits.

WHAT MEDICAL EVIDENCE DO I NEED TO START MY CLAIM?

If your accident occurred before November 1, 1996, you will need to submit a **Health Practitioner's Certificate** to the insurer.

If your accident occurred after November 1, 1996, and you are claiming weekly benefits, you will need a **Disability Certificate.**

These certificates are part of the Application for Accident Benefits package the insurer sends you. These certificates must be filled out by a qualified health practitioner. This is usually a medical doctor, chiropractor, dentist, psychologist or physiotherapist. The insurer should pay your health practitioner directly for filling out the certificate. These certificates provide the insurer with information on the cause and nature of your injury and whether your injuries prevent you from doing your regular activities.

DO I NEED A SPECIAL CERTIFICATE BEFORE I CAN GET TREATMENT?

If your accident occurred before November 1, 1996, you are not required to submit a special form before you receive medical treatment. However, an insurer may request a **Health Practitioner's Certificate** after you have started treatment, to ensure it is reasonable and necessary.

The insurer may also ask you to provide a certificate for any medical or rehabilitation service or item which you have paid for, or intend to pay for, before they will reimburse you.

If your accident occurred after November 1, 1996, your insurance company will include a **Treatment Plan** form in your Application for Accident Benefits. You must provide your insurer with a completed treatment plan signed by your health practitioner before starting any treatment or purchasing any rehabilitation items or services. In some cases, your insurer may agree to pay for an expense that is not provided for in a treatment plan where the insurer is satisfied that the expense is reasonable and necessary. Some insurers may waive the requirement for a Treatment Plan altogether. You should discuss this requirement with your insurer directly. The Treatment Plan form asks for information on the types of goods and services you need, how long treatment is expected to continue, who will treat you and what the goods or services will cost. The insurance company will respond to each item listed on the treatment plan.

What is an insurer's medical examination?

In order to determine whether your claim for weekly benefits should continue, or whether your claim for medical or rehabilitation benefits continues to be reasonable or necessary, the insurer may ask you to attend a medical examination at their cost.

The SABS provides that your insurance company can ask you to be examined by one or more health professionals — ones it chooses — for an opinion about your claim. It is allowed to do so "as often as is reasonably necessary."

If you are asked to attend an insurer's medical examination, remember:

- The insurer's medical examination usually provides an assessment of your current medical condition and treatment needs.
- If you fail to attend the examination, depending on the version of the SABS in effect, and the type of benefits involved, the insurance company may terminate your benefits until you attend. You cannot commence mediation if you have not made yourself reasonably available for an insurer's medical examination.
- If you cannot attend on the date scheduled, you should notify your insurance company right away, because the company will still have to pay the health professional if you do not show up. Your insurer may then claim you are responsible for these expenses.

The insurance company is required to:

- Consider your convenience and particular situation when scheduling medical appointments, and give you reasonable notice of the appointment.
- Provide copies of the examination report to you and/or your health professional.

What if I want another opinion?

If you want a medical report from your own health professional to respond to the insurer's medical report, you are responsible for paying for this report. In some cases, your insurance company may pay your expenses.

Designated Assessment Centres

Designated Assessment Centres (DACs) have been approved by the government to provide independent assessments of your disability or of your medical, rehabilitation and attendant care needs. DACs can conduct assessments at the request of either the claimant or the insurance company. They provide a speedy, neutral way to evaluate claims.

You may be required to attend a DAC if your accident occurred on or after January 1, 1994. Depending on the version of the SABS in effect at the time of your accident, the centres may also assess your earning capacity, and the types of employment that might be available to you if you suffer from long-term physical or psychological problems, and whether your injuries are catastrophic.

The DAC assessment usually involves a medical examination. The assessment can take less than a day or as long as two weeks to complete.

If you request a DAC assessment, or you are required by the insurer to go to one, then you must provide the DAC with all relevant medical documentation. Make sure the health practitioners who have treated you provide their reports and records to the DAC directly.

The *Statutory Accident Benefits Schedule* sets out the conditions under which you may be required to be assessed at a DAC. These conditions vary depending on the date of the accident, so it is important to refer to the version of the SABS in effect at that date.

For accidents occurring before November 1, 1996, you may be required to undergo a DAC assessment:

- if you claim medical expenses (other than eyewear, dentures or transportation expenses) incurred more than 8 weeks after the accident; or if the insurance company has already paid out more than $2,000 in medical benefits;
- if you apply for social rehabilitation or vocational rehabilitation expenses, or for attendant care benefits; and
- if you reject the insurance company's assessment of post-accident earning capacity (for claims over two years in length).

For accidents occurring after November 1, 1996, you may be required to undergo a DAC assessment:

- if goods and services are recommended in a treatment plan for which an insurer will not pay;
- if you apply for attendant care benefits; or
- if you apply for a catastrophic impairment determination.

Is a DAC required when the insurer stops paying weekly benefits?

For all accidents occurring on or after January 1, 1994, it is up to you to request a DAC assessment when your insurer decides to stop weekly benefits. Your request must be in writing to your insurance company.

Remember, if you request a DAC assessment within 14 days of when you were first told that the insurer will stop the benefit, the weekly benefit will continue to the date of the DAC assessment.

The insurer will pay for the DAC assessment. However, if you fail to attend without reasonable excuse:

- the insurer may ask you to pay the fee charged by the DAC; and
- you may not be permitted to go to mediation or arbitration.

If you can't go to a DAC assessment that has been scheduled, notify the DAC and the insurer right away.

If you have a dispute with an insurer, an insurer's medical examination and a DAC report as well as your own health practitioner's certificates can be used as evidence in mediation, neutral evaluation and arbitration.

This is a brief summary of a complex topic. Please refer to the applicable version of the Statutory Accident Benefits Schedule for more precise information.

For more information, see Practice Note 4, "Exchange of Documents for an Arbitration Hearing", which describes the medical documents required for an arbitration hearing.

How do I get more information?

Our telephone numbers are:
- from Toronto, call (416) 250-6714
- from outside Toronto, phone 1 (800) 517-2332

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PRACTICE NOTE
NOTE PRATIQUE 2

Dispute Resolution Group / Groupe de réglement des differends

THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS

Reaching a Settlement Within the Dispute Resolution Process

What is a Settlement?

A settlement is an agreement between an insurance company and an insured person that finally ends a dispute about the insured person's entitlement to one or more benefits under the *Statutory Accident Benefits Schedule (SABS)*. You can settle one or more issues while others remain in dispute.

What Is a Release?

When you reach a settlement, you may be asked to sign a release form. The release is an agreement with the insurance company that in exchange for the agreed-upon amount you will not make any further claims concerning the disputes that are being settled. Once you sign the release, and two business days have passed, you have no further right to re-open the issue.

Written Notice

Your insurance company must provide you with the following before you enter into an agreement that finally ends your claim or dispute about entitlement to one or more benefits:

- A description of the benefits that are available to you under the SABS and any other benefits that may be available under your specific insurance contract;
- A description of the impact of the settlement on all of these benefits, including a statement explaining that the settlement limits the right to mediate, litigate, arbitrate, appeal, or in any way vary the terms of the settlement;
- A statement telling you that you have two business days after reaching the agreement to change your mind and deliver a written notice to the insurance company cancelling the settlement; and
- A statement of the tax implications of the settlement, if any.

Can I Change My Mind?

You have two business days to change your mind after agreeing to a settlement. You must tell the insurance company in writing that you wish to do so, within two business days. After the two days, the settlement is binding on you and the insurance company.

Obligations

Both sides in the dispute are required to live up to the terms of the settlement. The agreement can be enforced through the courts.

Does the Commission have any Role in Negotiating Settlements?

Mediators help the parties negotiate terms of settlement. Settlement is also discussed where the parties are proceeding to a neutral evaluation, or at an arbitration pre-hearing discussion. Parties may reach a settlement at any time during arbitration. However, Commission mediators, neutral evaluators and arbitrators are not involved in preparing and signing releases or ensuring that the terms of the settlement are followed.

What if I want a legal opinion?

You do not need a lawyer to negotiate a settlement, but in many circumstances a lawyer's advice on settlement terms can be helpful. If you have any concerns about signing a release, get legal advice.

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PRACTICE NOTE
NOTE PRATIQUE

3

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THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS AND INSURERS

AUTHORITY TO BIND

WHAT IS AUTHORITY TO BIND?

Anyone representing an insurance company or an insured person at mediation, neutral evaluation or arbitration will be discussing and negotiating terms of settlement of disputes about accident benefits. A representative who has "authority to bind" has been given the power to act on behalf of the party being represented without having to go back to consult or get instructions.

A lawyer or an employee representing an insurance company must have the authority to change the company's position based on the evidence presented by the insured at a mediation, neutral evaluation or arbitration.

Authority to bind does not just concern financial issues. The representatives must be able to speak and negotiate on all issues.

It is essential for people claiming benefits to be at the mediation, neutral evaluation or arbitration proceeding to hear and discuss settlement offers and give instructions to any representative.

WHAT HAPPENS IF THERE IS NO AUTHORITY TO BIND?

If a party is unable to attend (for example, you are confined to hospital), the mediator, neutral evaluator or adjudicator can adjourn a proceeding, with or without conditions, if the representative of any party involved is not authorized to bind that party to an agreement. The adjournment can be on whatever terms the mediator, neutral evaluator or adjudicator considers to be appropriate.

WHY IS AUTHORITY TO BIND SO IMPORTANT?

If the representatives do not have authority to bind, a settlement discussion can break down into a series of statements like "I'll have to check that with my client." This can lead to drawn-out, fruitless discussions that waste the time of everyone involved.

WHAT FORM DOES THE AUTHORITY HAVE TO BE IN?

The authority to bind can be verbal or in writing.

HOW DO I GET MORE INFORMATION?

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PRACTICE NOTE
NOTE PRATIQUE
4

Dispute Resolution Group / Groupe de réglement des differends

THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS AND INSURERS

EXCHANGE OF DOCUMENTS

This Practice Note outlines the role and the need for early disclosure of supporting documents in the Commission's dispute resolution process. The note offers general guidelines as to the type of documents that may be relied upon to support your claim, and when they should be gathered and exchanged with the other party. In certain cases, documents relating to a period more than one year prior to the accident may be relevant and ought to be produced.

A. DOCUMENTS

Documents that may assist to resolve a dispute vary with the issues in dispute, but can include the following:

1. Where disability benefits are in dispute:

- **Clinical notes and records of physicians** who treated the insured person during the year leading up to the accident and after the accident.
- **Ambulance call reports** if the insured person was transported from the accident by ambulance.
- **Hospital records** if the insured person has received treatment at a hospital in the year before the accident or after the accident.
- **Records of the Workers' Compensation Board,** if the insured person was receiving workers' compensation benefits at the time of the accident or in the preceding year.
- **Reports and clinical notes of any medical examination of the insured person that was requested by the insurance company** under the *Statutory Accident Benefits Schedule.*
- **Medical reports in the possession of the insurance company**, such as those prepared by the insured person's treating physicians.
- **An OHIP statement** listing the physicians who have treated the insured person in the year before the accident and after the accident, if it is unclear who has treated the insured person.
- **Surveillance or investigative evidence** a party intends to rely on. The party must provide particulars of the names and qualifications of any person who took such evidence, including the dates, times and places where any surveillance or investigation was undertaken. The party must provide copies of all surveillance evidence taken or prepared by anyone upon whose evidence the party intends to rely at the hearing.
- **Certain employment records**, such as a job description.

2. Where the amount of benefits is in dispute:

- **Certified income tax returns** from Revenue Canada for the year before the accident, and the year of the accident.

- **Financial statements** for the year before the accident and the year of the accident in the case of self-employed claimants. In certain circumstances, more detailed raw financial documentation may be required such as bank statements and records.

- **Any application for Canada Pension Plan disability benefits** and a **copy of the granting letter**, if it appears that the insured person has applied for or received these benefits.

- **A copy of any health or disability insurance policy**, if it appears that the insured person had coverage at the time of the accident, and a **copy of any application form or granting letter**.

- **Certain employment records**, such as payroll records, for the year before the accident.

B. Documents in Mediation

It is important that parties start discussions about exchanging documents **BEFORE** applying for mediation. Parties should immediately begin to collect material from sources, such as doctors, employers, or accountants. Producing documents and providing them to both the other party and the mediator at an early stage, greatly improves the chances for a successful mediation. Recent amendments to the *Insurance Act*, include a provision respecting early disclosure of key materials required to discuss the resolution of the issues in dispute. As a result of this amendment, you should review your file early to determine whether you will require any materials from the other party to discuss settlement, **and request these materials, in writing from the other party, as soon as possible.**

Remember that the request for documents at the mediation stage should be realistic and limited to those items which are critical to settlement discussions. The amount and type of documentation necessary to discuss settlement will vary from case to case. The intent of this provision is to facilitate settlement at this early stage of the dispute resolution process, not to introduce a time consuming and costly process of document exchange.

In the majority of cases the documents necessary to settle disputes at mediation, such as income tax returns, employment records and DAC reports are readily available. In some instances, documents such as bank statements must be secured at a nominal cost. It is not anticipated that in the majority of cases, historical records such as past medical clinical notes and records and OHIP statements will be necessary to discuss settlement at mediation. Records of this nature are expensive and take a significant amount of time to secure. They are more commonly requested at the arbitration stage of dispute resolution.

If either party objects to providing documents requested by the other, they should immediately communicate their objection and their reasons for objecting in advance of the mediation.

If mediation fails, the ***Report of the Mediator*** will **only** contain a list of materials that were requested by the parties in writing, which have not been produced and that, **in the opinion of the mediator were required for the purpose of discussing settlement,** of the issues in dispute at mediation.

The ***Report of the Mediator*** will **not** necessarily list all of the materials requested by the parties for discussion at mediation.

The failure to produce relevant documentation by a party as outlined in the ***Report of the Mediator*** may be considered by an arbitrator at the conclusion of a hearing, when deciding a claim for expenses.

C. Documents in Neutral Evaluation

Parties wishing to proceed to neutral evaluation within an arbitration proceeding at the Commission, must jointly certify that all the documents listed in the ***Report of Mediator*** have been exchanged, and that no other documentation is required for an evaluation of the issues in dispute. The person appointed to conduct the neutral evaluation may request additional information to assist in evaluating the issues in dispute.

If the dispute does not settle as a result of neutral evaluation, the evaluator will prepare a ***Report of the Neutral Evaluator*** listing any materials he or she requested, that were not provided by the parties.

The failure to produce relevant documentation by a party as outlined in the ***Report of the Neutral Evaluator*** may be considered by an arbitrator at the conclusion of an arbitration hearing, when deciding a claim for expenses.

D. Documents in an Arbitration Hearing

Parties to an arbitration should exchange all documents necessary to decide the issues in dispute.

This document exchange should be worked out between the parties and their representatives as soon as possible, and in any event, well before the pre-hearing discussion.

The parties should contact each other and:

- disclose what documents they intend to use at the hearing;
- arrange to give the documents to the other side;
- request any documents that they think they require from the other side; and
- arrange to share documents obtained from third parties.

As a general rule, the party asking for the document is responsible for paying the cost of getting it. When an insurance company arranges to collect documents directly from a third party, it may require the applicant to authorize the collection beforehand. The company must give copies of any documents it obtains to the applicant, as soon as possible.

Where the parties to the arbitration cannot agree which documents to exchange, the pre-hearing arbitrator will rule on what is required.

Where third parties (like hospitals or doctors) are asked to supply documents, the arbitrator will insist that parties make their own reasonable efforts to obtain the documents from the third

party before issuing an order requesting the third party to release the documents. One exception to this practice is a request for information from OHIP where, to speed up the process, an arbitrator will make an order at the parties' request. The pre-hearing arbitrator has the final say on what documents must be produced or exchanged **prior** to the arbitration hearing. The hearing arbitrator has the final say on what documents will be considered **during** the hearing.

Arbitration is designed to be relatively informal and quick. It does not have the broad discovery and disclosure processes of the court system. Parties to an arbitration can participate most effectively by promptly disclosing all relevant documents well before the date of the arbitration pre-hearing discussion.

Failing to produce documents well in advance of a hearing can result in adjournments and delays. Furthermore, if documents are not produced promptly, the hearing arbitrator may refuse to admit the documents into evidence or may draw an adverse inference against the party who failed to produce the document. The hearing arbitrator may also deny expenses to that party.

How do I get more information?

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PRACTICE NOTE
NOTE PRATIQUE 5

Dispute Resolution Group / Groupe de réglement des differends

THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS AND INSURERS

MEDIATOR REFERRAL TO NEUTRAL EVALUATION

WHAT IS NEUTRAL EVALUATION?

Neutral evaluation is a process designed to encourage the settlement of disputes in certain types of cases. A neutral evaluator will give you and your insurance company a frank review of both of your positions, as well as an assessment of the probable outcome, or range of outcomes, should the dispute be decided in private arbitration, arbitration at the Commission or in court.

Neutral evaluation provides the parties with an additional opportunity to settle outstanding disputes and avoid adjudication. This step in the dispute resolution process has the potential to save the parties time and the expenses associated with taking the dispute through the full process of arbitration or to court. Under the *Insurance Act*, neutral evaluation takes place after mediation fails and before a case proceeds to arbitration or court.

HOW DO I OBTAIN NEUTRAL EVALUATION?

Neutral evaluation can be obtained privately or at the Commission, as part of the Commission's arbitration process. If you and your insurer choose private neutral evaluation (under the *Insurance Act*), you must agree upon the choice of the neutral evaluator, negotiate the fee, and determine who will pay. The evaluator must then be appointed by the Commission's Director of Arbitrations. The appointment process is simple. The parties write the Director of Arbitrations providing the name, address and telephone number of the neutral evaluator. You must also include written confirmation that the parties agree to pay for the evaluation and that the neutral evaluator has agreed to conduct the evaluation in accordance with the requirements of the *Insurance Act*. Based on this information, the Director of Arbitrations will appoint this individual as your neutral evaluator and provide him or her with a copy of the ***Report of the Mediator*** as well as an approved format for the ***Report of the Neutral Evaluator***.

The Commission is not responsible for payment of the private evaluator's fees nor does it maintain an approved or recommended list of private neutral evaluators.

To obtain neutral evaluation at the Commission you must first apply for arbitration and pay the filing fee. You must indicate on your ***Application for Arbitration*** that you wish to participate in neutral evaluation. If the insurer agrees, the Director of Arbitrations will appoint a neutral evaluator from within the Commission and will suspend the arbitration process until the neutral evaluation has been completed. If your case does not settle at neutral evaluation, your dispute will normally be fast-tracked to an arbitration hearing, bypassing the pre-hearing stage.

If a mediator recommends that you and your insurance company engage in neutral evaluation, your case must proceed through private neutral evaluation that is recognized under the *Insurance Act*. This process must be completed before your dispute can proceed to private arbitration, arbitration at the Commission, or court.

When does a mediator make a referral to neutral evaluation?

Mediators consider stringent criteria before recommending a referral to neutral evaluation.

First, the mediator must be of the opinion that the neutral evaluation process will likely result in a settlement of your dispute. This opinion will be based on many factors, including the nature of the dispute, the parties' understanding of their case, their expectations, and their reasonableness.

Second, the mediator will evaluate whether the parties have fully documented their positions. Have they provided disclosure to the other side at mediation or can they realistically exchange the documents required within 30 days of the date of the ***Report of the Mediator***?

Third, if both parties agree to proceed to neutral evaluation it will be noted in the ***Report of the Mediator***. In this case, a mediator referral is not required. The mediator will outline the features of both private and Commission-delivered neutral evaluation. The parties then may choose the route they will pursue.

Fourth, if mutual consent cannot be reached, but the insured person wishes neutral evaluation, the mediator can consider a referral. Under these circumstances the mediator will outline the features of private neutral evaluation as detailed under the *Insurance Act*.

Fifth, before making the referral to private neutral evaluation, the mediator must ensure that the parties have agreed how they will pay for these services. The parties will have to agree on who will perform the evaluation and obtain the appointment of this person's service by the Director of Arbitrations, as outlined above.

How do I contact the Office of the Director of Arbitrations?

The Director of Arbitrations' office can be contacted at:

Ontario Insurance Commission
Dispute Resolution Group
Arbitrations Unit
5160 Yonge Street, 14th Floor
North York ON M2N 6L9
phone (416) 590-7020
fax (416) 590-7077

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PRACTICE NOTE
NOTE PRATIQUE 6

Dispute Resolution Group / Groupe de réglement des differends

THIS PRACTICE NOTE IS INTENDED FOR USE BY APPLICANTS AND INSURERS

THE ARBITRATION PRE-HEARING DISCUSSION

Parties to an arbitration are usually required to participate in one or more pre-hearing discussions of their case before the actual arbitration hearing. This discussion takes place shortly after the applicant receives the insurance company's ***Response by Insurer***.

WHY DO WE HAVE A PRE-HEARING DISCUSSION?

The pre-hearing discussion gives the parties an opportunity to talk with an arbitrator about the case before the hearing. The arbitrator will help to:

- attempt to settle some or all of the issues in dispute;
- clarify the issues to be arbitrated;
- explain the rules of the hearing;
- review what witnesses and evidence will be brought to the hearing;
- decide which documents should be exchanged if the parties cannot agree;
- set a mutually convenient date and location for the hearing.

DOES EVERYONE MEET IN PERSON?

The pre-hearing discussion can be held in person or by telephone conference call, at the arbitrator's discretion.

Whether the discussion is in person or by telephone, both the applicant and the representative from the insurance company should take part. Arbitrators have noted that the absence of parties from the pre-hearing frequently impedes settlement discussions — even when the parties are represented by legal counsel who participate in the pre-hearing on their behalf.

Clients who cannot participate in person are expected to be available to participate in the pre-hearing discussion by phone.

An arbitrator will chair the discussion. The arbitrator who chairs the pre-hearing discussion will *generally not* be the one who hears the case.

WHAT DO I BRING TO THE PRE-HEARING DISCUSSION?

Don't wait for the pre-hearing discussion to begin preparing your case.

Get updated medical information, financial documents, or recent tax returns before the pre-hearing discussion.

Parties should exchange copies of all the documents they intend to use at the actual hearing before the pre-hearing discussion. See **Practice Note 4**, "Exchange of Documents", in this Section.

If you have been unable to exchange documents in advance, please bring along two sets of photocopies: one for the arbitrator and one for the other party. These photocopies will be exchanged at the pre-hearing.

The arbitrator will ask about the witnesses who will be called during the hearing. Witnesses typically provide information about the accident, about the applicant's employment and income, or about the applicant's medical condition.

How long after the pre-hearing discussion until the hearing?

At the pre-hearing, the arbitrator will set a convenient date for the hearing. Generally, this date will be several months after the pre-hearing discussion. Once this date is set, changes will only be made in special circumstances. See **Practice Note 8**, "Adjournments", in this Section.

You must have all your papers, updated medical reports and witnesses ready for the hearing date set.

How do I get more information?

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THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS AND INSURERS

ATTENDANCE OF A WITNESS TO AN ARBITRATION HEARING BY SUMMONS

If you need a witness to attend an arbitration hearing you must arrange three things: the summons, an affidavit attesting to the summons, and the correct attendance fees.

First, the witness must receive a summons (called a ***Summons to Witness***) to the hearing and a payment for attending.

Next, the person who delivers the summons must file an affidavit (swearing that the summons and witness fees were delivered in person) with the Commission.

SUMMONING A WITNESS

Step 1: Getting the proper forms

If you wish to summon a witness, get a ***Summons to Witness*** form (**Form 0** found in **Section G** of the Code) from the Commission. The Commission can mail or fax the form to you, or it can be picked up in person. If you wish to have a witness at your hearing, you should start this process as early as possible before the hearing date.

Step 2: Filling out the form

Be sure you include all necessary information on the ***Summons to Witness*** form before you pass it to your witness:

- ✔ the commision's file number;
- ✔ your name;
- ✔ the name of the insurance company;
- ✔ the name and address of the person receiving the summons (witness);
- ✔ the date, time and place of the hearing;
- ✔ a list of the documents the witness should bring to the hearing.

Step 3: Delivering the form

The summons must be delivered to the witness in person. You or your representative can deliver the summons, or you can hire a process server (check the Yellow Pages of your telephone directory). You must also be sure to pay the witness at this time. You must deliver the ***Summons to Witness*** at least **five days** before the commencement of the hearing.

CALCULATING PAYMENT TO THE WITNESS

The standard witness fee is $50 a day for each day of the hearing the witness attends. But an expert witness, like a doctor or an accountant, often charges more. You are also responsible for paying travelling expenses to the witness. These vary:

- If a witness lives in the city where the hearing is held, you are responsible for $3 per day in travelling expenses;

- If a witness lives outside of the city but within 300 kilometres, you must pay 24 cents a kilometre each way;

- If the witness lives more than 300 kilometres from the hearing, you must pay travel expenses equalling the minimum return air fare, plus 24 cents a kilometre, each way, from the witness's home to the airport and from the airport to the hearing;

- Overnight accommodation and meals can be up to $75 per day.

Remember, the witness must receive payment when he or she receives the summons.

Important

Be sure you keep your copies of the summons and of the money order or cheque that goes to the witness for fees and expenses. At the end of your hearing, you can ask the arbitrator to award you your costs for witness fees, travel expenses and swearing the ***Affidavit of Service for a Summons***. (For more information, see **Schedule to Expense Regulation** found in **Section F** of the Code).

Getting an affidavit of service

Before the hearing, the Commission must receive a signed affidavit (called an ***Affidavit of Service for a Summons,*** **Form P** found in **Section G** of the Code) swearing that the witness was handed the summons in person and paid to attend the hearing. The affidavit can be delivered to the Commission in person or by regular, registered or certified mail. It can also be faxed to the Commission as long as the original is mailed to the Commission.

In the ***Affidavit of Service for a Summons***, the person who delivered your summons swears an oath that he or she has personally handed the summons to the witness. Swearing, or affirming, is done in front of a commissioner of oaths such as a lawyer, notary public, or a designated law clerk or paralegal. Forms will be available wherever you find a designated commissioner of oaths. You may have to pay the commissioner of oaths for this service.

What happens if a witness doesn't show up for the hearing?

Having your witness attend the hearing may be critical to your case. It is vital that your witness is properly summoned and that you keep copies of all documents. If your witness does not attend the hearing, fails to stay, or does not bring the documents listed on the summons, you may not be able to prove your case.

What happens next depends largely on whether the summons and the affidavit were properly prepared and delivered. The arbitrator will review the affidavit to ensure that everything that needed to be done was properly done. If your copies of the documents show that the witness was summoned properly, the arbitrator may grant an adjournment and set another hearing date, or a sheriff's warrant may be obtained through the courts, to have the witness brought to the hearing.

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THIS PRACTICE NOTE IS INTENDED FOR USE BY APPLICANTS AND INSURERS

ADJOURNMENTS

The Commission has an obligation to conduct arbitrations efficiently and speedily. Parties are contacted and agree to pre-hearing and hearing dates well in advance of the dates set. Therefore, adjournments are granted only sparingly once dates have been set.

WHEN WILL ADJOURNMENTS BE GRANTED?

Requests for adjournments will only be considered in three circumstances:

- in cases of personal emergencies, such as serious illnesses or deaths in the family
- for valid reasons relating to the hearing itself, such as an imminent settlement, or medical or other critical evidence that is **unavoidably** delayed
- when a lawyer is involved in a trial or other proceeding that was scheduled to conclude before the start of the arbitration and which has continued or been held over into the time scheduled for the arbitration.

WHEN WILL ADJOURNMENTS BE REFUSED?

Adjournments will normally be refused if they do not fall into one of the three categories mentioned above. Common circumstances in which adjournments are refused include the following:

- scheduling conflicts for the parties or their lawyers (except for conflicts with pre-set trial dates as noted above)
- where the parties have not made reasonable efforts to comply or delayed their compliance with undertakings and orders made at the pre-hearing
- where the parties have not made early arrangements to ensure witness attendance
- where parties have not made early arrangements for further medical examinations or follow-up.

NOTICE REQUIREMENTS

Seven days notice is generally required for an adjournment request. The request should be made in writing to the Registrar with a copy to the other parties. The request must outline the reasons for the adjournment and indicate whether the other parties consent to it. Where there is consent, alternative hearing dates that are acceptable to all parties must be proposed. The party requesting an adjournment should contact the other parties involved in the hearing to arrange acceptable alternative dates before asking for the adjournment.

The Registrar may deal with requests on less than seven days notice by conference call.

The new hearing date

It is advisable to provide more than one alternative date, so that the arbitrator can avoid conflicts with other hearings. An adjournment *sine die* (that is, with no new hearing date set) will be granted only in extraordinary circumstances (for example, a severe, long-term illness).

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PRACTICE NOTE
NOTE PRATIQUE
9

Dispute Resolution Group / Groupe de réglement des differends

THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS AND INSURERS

PROCESS FOR SETTLING DISPUTES BETWEEN AUTO INSURANCE COMPANIES

This Note is to advise claimants and insurers of the provisions of Regulation 283/95 **Disputes Between Insurers** ("the Regulation"). The Regulation ensures that claimants will have access to statutory accident benefits where two or more insurers are disputing which one has the responsibility to pay accident benefits. The Regulation also requires that disputes between insurers about which insurer is required to pay accident benefits be referred to private arbitration under the *Arbitrations Act, 1991*. Such disputes between insurers are no longer dealt with through the dispute resolution process at the Commission. A copy of this Regulation is included with this Practice Note.

BACKGROUND – SECTION 268 OF THE *INSURANCE ACT*

Section 268 of the *Insurance Act* creates rules for determining which automobile insurance company is responsible for paying accident benefits in a given set of circumstances. The section is used to determine which insurer is liable to pay benefits when the claimant does not have an auto insurance policy of his or her own, or where coverage may be available under more than one policy. In some circumstances, section 268 requires a specific insurance company to deal with the claim. In other situations, two or more companies may be liable to pay benefits, and a claimant may choose the insurer from which to claim benefits. An excerpt from s.268 outlining the priority rules for paying benefits is attached.

Disputes between insurers can arise in various ways. For example, in cases where a passenger involved in a car accident has no auto insurance of his or her own, it may not be clear whether the passenger looks to the insurance policy of their spouse, parents, or another vehicle involved in the accident. A spouse or dependant of a named insured must look to that policy for payment of accident benefits. A person who is not a spouse or dependant will have to look to the insurance policy of a vehicle involved in the accident.

REGULATION 283/95 – DISPUTES BETWEEN INSURERS

This Regulation ensures that accident victims will not be denied statutory accident benefits simply because the first insurer applied to for benefits thinks another insurer should pay. Section 2 of the Regulation requires the **first** insurer that receives an application to adjust the claim and to pay benefits to which the insured person is entitled, pending resolution of any dispute as to which insurer is required to pay benefits (see Section 2 of the Regulation). The first insurer cannot refuse to pay accident benefits on the basis that the insured person may have approached the wrong insurance company.

If an insurer believes that another insurance company ought to be paying the claim, it is obliged to notify the other company **within 90 days** of receiving a completed application for statutory accident benefits. It also must notify the insured person that it believes another company is responsible, and that it proposes to transfer the claim to that company. If the insured person objects to the claim being transferred, he or she must notify the insurer of the objection **within 14 days.** Otherwise, the insured person will not be able to participate as a party in the dispute between insurers as to which insurer should pay.

The Regulation removes these disputes between insurers from the dispute resolution process at the Commission. Disputes between insurers are now settled through private arbitration under the *Arbitrations Act, 1991.* If the insured person has given notice that he or she objects to the transfer of the claim, the insured person, or his or her representative, may take part in the arbitration of the dispute under the *Arbitrations Act.* All such arbitrations must be commenced **within a year** from the date that the first insurance company gave notice that it believes another company is liable.

Obligations of insurers

The Regulation requires the insurer who first receives an application for benefits to consider entitlement and adjust the claim as it would any other, including seeking an independent medical examination, or initiating the designated assessment or mediation process as appropriate. It does not allow the insurer to ignore a claim where it believes another insurer is liable to pay under section 268 of the *Insurance Act.*

Where the first insurer believes it is the wrong insurer and also claims that the insured person is not entitled to benefits under the *Statutory Accident Benefits Schedule,* it must respond to the claim on two separate fronts – issuing the notice to the insurer it believes is responsible under s.268, and following the procedures for denying a claim through the normal dispute resolution process at the Commission.

Obligations of insureds

The Regulation is intended to ensure that a claimant is not caught between two insurers, both of which are disputing their liability to pay benefits. However, the Regulation cannot operate properly without a clear record as to which insurer first receives an application for benefits. As a result, claimants are advised to carefully consider which insurer is obligated to pay the claim under the provisions of s.268 of the *Insurance Act,* **before** submitting an application. In order to prevent disputes over which insurer first received an application, **the claimant is advised to initially submit only one application for benefits.**

If the insurer to whom the application was submitted does not respond to the claim, or delays or denies coverage on the basis that another insurer is liable to pay, under s.268 of the *Insurance Act*, the claimant should contact the Market Conduct Branch of the Commission. The claimant may also file an ***Application for Mediation*** against the first insurer regarding a delay in payment.

Under the Regulation a claimant is required to provide the insurers with all the relevant information that is needed to determine which insurer is required to pay (see section 6 of the Regulation). He or she is not required to participate in the private arbitration that will occur if the dispute is not settled. A claimant is entitled to object to the transfer of a claim (unless the claim has been made against the

Motor Vehicle Accident Claims Fund – s.11) and to participate as a party in the private arbitration if he or she files an objection **within 14 days** of receiving notice of the dispute (see s.5 of the Regulation).

Liability under section 268 of the *Insurance Act* versus entitlement under the *Statutory Accident Benefits Schedule*

In some cases insurers have expressed uncertainty about how they should deal with a claim where there is a dispute between insurers.

If the insurer's position is that the claimant is not eligible for accident benefits, then the dispute should be settled by commencing mediation at the Commission.

If the insurer's position is that responsibility to pay belongs to another insurer, then it is a dispute under Regulation 283/95. The first insurer must notify the other insurer and the claimant, as outlined above, and resolve that dispute through private arbitration.

If the first insurer has a number of reasons for denying the claim, some of which are based on lack of entitlement, and others based on a liability question, it should dispute the claim in the normal manner before the Commission on the entitlement dispute. It should also issue a notice under the Regulation to the insurer that it believes would be required to pay, in the event it is unsuccessful on the entitlement issues. The second insurer may seek permission to join the proceeding concerning entitlement to accident benefits started by the first insurer at the Commission.

This is a brief summary of a complex topic. Please refer to Regulation 283/95 and the *Insurance Act* for more precise information.

How do I get more information?

The Commission telephone numbers are:

From Toronto, call: (416) 250-6714
From outside Toronto, phone: 1 (800) 517-2332

To reach the Market Conduct Branch, the telephone numbers are:

From Toronto, call (416) 250-7250
From outside Toronto, phone 1 (800) 668-0128

Cette publication est également disponible en français

Excerpt from the Insurance Act
R.S.O. 1990, C.1.8, as amended

Statutory accident benefits

268.—(1) Every contract evidenced by a motor vehicle liability policy, including every such contract in force when the *Statutory Accident Benefits Schedule* is made or amended, shall be deemed to provide for the statutory accident benefits set out in the *Schedule,* and any amendments to the *Schedule,* subject to the terms, conditions, provisions, exclusions and limits set out in that *Schedule.*

Liability to pay

(2) The following rules apply for determining who is liable to pay ***statutory accident benefits:***

1. In respect of an occupant of an automobile,

   i. the occupant has recourse against the insurer of an automobile in respect of which the occupant is an insured,

   ii. if recovery is unavailable under subparagraph i, the occupant has recourse against the insurer of the automobile in which he or she was an occupant,

   iii. if recovery is unavailable under subparagraph i or ii, the occupant has recourse against the insurer of any other automobile involved in the incident from which the entitlement to ***statutory accident benefits*** arose,

   iv. if recovery is unavailable under subparagraph i, ii or iii, the occupant has recourse against the Motor Vehicle Accident Claims Fund.

2. In respect of non-occupants,

   i. the non-occupant has recourse against the insurer of an automobile in respect of which the non-occupant is an insured,

   ii. if recovery is unavailable under subparagraph i, the non-occupant has recourse against the insurer of the automobile that struck the non-occupant,

   iii. if recovery is unavailable under subparagraph i or ii, the non-occupant has recourse against the insurer of any automobile involved in the incident from which the entitlement to ***statutory accident benefits*** arose,

iv. if recovery is unavailable under subparagraph i, ii or iii, the non-occupant has recourse against the Motor Vehicle Accident Claims Fund.

LIABILITY

(3) An insurer against whom a person has recourse for the payment of ***statutory accident benefits*** is liable to pay the benefits..

CHOICE OF INSURER

(4) If, under subparagraph i or iii of paragraph 1 or subparagraph i or iii of paragraph 2 of subsection (2), a person has recourse against more than one insurer for the payment of ***statutory accident benefits,*** the person, in his or her absolute discretion, may decide the insurer from which he or she will claim the benefits.

(5) Despite subsection (4), if a person is a named insured under a contract evidenced by a motor vehicle liability policy or the person is the spouse or a dependant, as defined in the *Statutory Accident Benefits Schedule,* of a named insured, the person shall claim statutory accident benefits against the insurer under that policy.

SAME

(5.1) Subject to subsection (5.2), if there is more than one insurer against which a person may claim benefits under subsection (5), the person, in his or her discretion, may decide the insurer from which he or she will claim the benefits.

SAME

(5.2) If there is more than one insurer against which a person may claim benefits under subsection (5) and the person was, at the time of the incident, an occupant of an automobile in respect of which the person is the named insured or the spouse or a dependant of the named insured, the person shall claim statutory accident benefits against the insurer of the automobile in which the person was an occupant.

Excerpt from the Insurance Act R.S.O. 1990 c. I.8, as amended

Ontario regulation 283/95
disputes between insurers

1. All disputes as to which insurer is required to pay benefits under section 268 of the Act shall be settled in accordance with this Regulation.

2. The first insurer that receives a completed application for benefits is responsible for paying benefits to an insured person pending the resolution of any dispute as to which insurer is required to pay benefits under section 268 of the Act.

3. (1) No insurer may dispute its obligation to pay benefits under section 268 of the Act unless it gives written notice within 90 days of receipt of a completed application for benefits to every insurer who it claims is required to pay under that section.

   (2) An insurer may give notice after the 90-day period if,

      (a) 90 days was not a sufficient period of time to make a determination that another insurer or insurers is liable under section 268 of the Act; and

      (b) the insurer made the reasonable investigations necessary to determine if another insurer was liable within the 90-day period.

   (3) The issue of whether an insurer who has not given notice within 90 days has complied with subsection (2) shall be resolved in an arbitration under section 7.

4. An insurer that gives notice under section 3 shall also give notice to the insured person using a form approved by the Commissioner.

5. (1) An insured person who receives a notice under section 4 shall also advise the insurer paying benefits in writing within 14 days whether he or she objects to the transfer of the claim to the insurers referred to in the notice.

   (2) If the insured person does not advise the insurer within 14 days that he or she objects to the transfer of the claim, the insured person is not entitled to object to any subsequent agreement or decision to transfer the claim to the insurers referred to in the notice.

(3) An insured person who has given notice of an objection is entitled to participate as a party in any subsequent proceeding to settle the dispute and no agreement between insurers as to which insurer should pay the claim is binding unless the insured person consents to the agreement or 14 days have passed since the insured person was notified in writing of an agreement and the insured person has not initiated an arbitration under the *Arbitrations Act,* 1991.

6. The insured person shall provide the insurers with all relevant information needed to determine who is required to pay benefits under section 268 of the Act.

7. (1) If the insurers cannot agree as to who is required to pay benefits or if the insured person disagrees with an agreement among insurers that an insurer other than the insurer selected by the insured person should pay the benefits, the dispute shall be resolved through an arbitration under the *Arbitrations Act, 1991.*

(2) The insurer paying benefits under section 2, any other insurer against whom the obligation to pay benefits is claimed or the insured person who has given notice of an objection to a change in insurers under section 5 may initiate the arbitration but no arbitration may be initiated after one year from the time the insurer paying benefits under section 2 first gives notice under section 3.

8. (1) Except as provided in this Regulation, the *Arbitrations Act, 1991* applies to an arbitration under this Regulation.

(2) The decisions of an arbitrator made under this Regulation shall be public.

9. (1) Unless otherwise ordered by the arbitrator or agreed to by all the parties before the commencement of the arbitration, the costs of the arbitration for all parties, including the cost of the arbitrator, shall be paid by the unsuccessful parties to the arbitration.

(2) The costs referred to in subsection (1) shall be assessed in accordance with section 56 of the *Arbitrations Act,* 1991.

10. (1) If an insurer who receives notice under section 3 disputes its obligation to pay benefits on the basis that other insurers, excluding the insurer giving notice, have equal or higher priority under section 268 of the Act, it shall give notice to the other insurers.

(2) This Regulation applies to the other insurers given notice in the same way that it applies to the original insurer given notice under section 3.

(3) The dispute among the insurers shall be resolved in one arbitration.

11. If the Motor Vehicle Accident Claims Fund receives an application for benefits, sections 4 and 5 do not apply and the insured person is not entitled to initiate or participate as a party in an arbitration under section 7.

Section D

Fees and Assessments

1. Fees – *(An application filing fee is charged to the party that initiates an arbitration, an appeal or a variation/revocation proceeding.)*

1.1 The application filing fee for an arbitration is **$100.** Only insured persons can file an application for arbitration.

1.2 The application filing fee for an appeal of an arbitration order is **$250.** Either an insured person or an insurer can file an appeal of an arbitration order.

1.3 The application filing fee for a variation/revocation of an arbitration or appeal order is **$100.** Either an insured person or an insurer can file a variation/revocation application.

2. Insurer Assessment – *(An assessment is charged to an insurer that is a named party to an arbitration, an appeal or a variation/revocation proceeding.)*

2.1 The insurer assessment charged to an insurer that is named as a party to an arbitration after March 31, 1997 where a neutral evaluation is commenced through the Commission is **$1,000.**

2.2 The insurer assessment charged to an insurer where an arbitrator has been appointed after the termination or completion of a neutral evaluation conducted at the Commission and the insurer has been assessed the **$1,000** referred to in 2.1 is **$2,000.**

2.3 The insurer assessment charged to an insurer that is named as a party to an arbitration proceeding after March 31, 1997 where an arbitrator is appointed without a neutral evaluation being commenced through the Commission is **$3,000.**

2.4 The insurer assessment charged to an insurer that is named as a party to an appeal is **$500.**

2.5 The insurer assessment charged to an insurer that is named as a party to a variation/revocation proceeding is **$500.**

2.6 Where a proceeding is consolidated with another proceeding, the insurer will be assessed only once.

3. Payment of Fees ~ By the Insured Person

3.1 An insured person must pay the fees outlined above in 1.1, 1.2, and 1.3, at the time of filing their application(s).

3.2 All fees must be paid by cash, cheque, or money order.

3.3 All cheques and money orders must be made payable to the order of the MINISTER OF FINANCE.

4. Payment of Fees and Insurer Assessment ~ By the Insurer

4.1 The Commission will invoice insurers on a quarterly basis for the fees outlined above in 1.2 and 1.3 and the insurer assessments outlined above in 2.1, 2.2, 2.3, 2.4 and 2.5. The invoice will provide each insurer with an accounting of the fees and assessments charged to their company for that quarter.

4.2 The Dispute Resolution charges (as outlined in 4.1) will be combined with the regular assessment for Commission costs for those insurers who pay the regular assessment on a quarterly basis.

SECTION E

SETTLEMENT REGULATION

August 1, 1995

EXCERPT FROM REGULATION 664 OF R.R.O. 1990, AS AMENDED BY ONTARIO REGULATION 780/93 MADE UNDER THE *INSURANCE ACT*

SETTLEMENTS – STATUTORY ACCIDENT BENEFITS

9.1 (1) In this section, "settlement" means an agreement between an insurer and an insured person that finally disposes of a claim or dispute in respect of the insured person's entitlement to one or more benefits under the *Statutory Accident Benefits Schedule*.

(2) Before a settlement is entered into between an insurer and an insured person, the insurer shall give the insured person a written notice that contains the following:

1. A description of the benefits that may be available to the insured person under the *Statutory Accident Benefits Schedule* and any other benefits that may be available to the insured person under a contract of automobile insurance.

2. A description of the impact of the settlement on the benefits described under paragraph 1, including a statement of the restrictions contained in the settlement on the insured person's right to mediate, litigate, arbitrate, appeal or apply to vary an order as provided in sections 280 to 284 of the *Act*.

3. A statement that the insured person may rescind the settlement within two business days after the settlement is entered into by delivering a written notice to the insurer.

4. A statement that the tax implications of the settlement may be different from the tax implications of the benefits described under paragraph 1.

5. If the settlement provides for the payment of a lump sum in an amount offered by the insurer and, with respect to a benefit under the *Statutory Accident Benefits Schedule* that is not a lump sum benefit, the settlement contains a restriction on the insured person's right to mediate, litigate, arbitrate, appeal or apply to vary an order as provided in sections 280 to 284 of the *Act*, a statement of the insurer's estimate of the commuted value of the benefit and an explanation of how the insurer determined the commuted value.

6. A statement advising the insured person to consider seeking independent legal, financial and medical advice before entering into the settlement.

(3) A settlement may be rescinded by the insured person, within two business days after the settlement is entered into, by delivering a written notice to the insurer.

(4) If the insurer did not comply with subsection (2), the insured person may rescind the settlement after the period mentioned in subsection (3) by delivering a written notice to the insurer.

(5) A restriction on an insured person's right to mediate, litigate, arbitrate, appeal or apply to vary an order as provided in sections 280 to 284 of the *Act* is not void under subsection 279(2) of the *Act* if,

(a) the restriction is contained in a settlement; and

(b) the insurer complied with subsection (2). O.Reg.780/93,s.7.

SECTION F

EXPENSE REGULATION

August 1, 1995

Excerpt from Ontario Regulation 664, R.R.O. 1990, as amended by Ontario Regulation 464/96 made under the *Insurance Act*

12. (1) The expenses set out in the Schedule are prescribed for the purpose of subsection 282(11) of the *Act*.

(2) An arbitrator may award expenses to an insurer or insured person under subsection 282 (11) of the *Act* if the arbitrator is satisfied that the award is justified, having regard to the following criteria:

1. Each party's degree of success in the outcome of the proceeding.

2. Conduct of the insurer or the insured person that tended to shorten or facilitate the proceeding or that tended to prolong, obstruct or hinder the proceeding, including failure to comply with undertakings or orders.

3. Whether the proceeding or any position taken by the insurer or the insured person during the proceeding was manifestly unfounded, frivolous, vexatious, fraudulent or an abuse of process.

4. The degree of complexity, novelty or significance of the factual or legal issues raised in the proceeding.

5. If the insurer or the insured person requests, any written offers to settle made after the conclusion of mediation and before the conclusion of the arbitration in accordance with the rules of practice and procedure applicable to the proceeding, including the terms of the offers, the timing of the offers and the responses to the offers, having regard to the result of the proceeding.

6. Any other matter related to the proceeding that the arbitrator considers relevant to the issue of whether an award of expenses is justified.

Schedule

Dispute Resolution Expenses

(Subsection 282 (11) of the Act)

1. The filing fees paid by the insured person when applying for arbitration may be awarded to the insured person.

2. The filing fees paid by the insured person or the insurer when appealing the order of an arbitrator or applying to vary or revoke an order may be awarded.

3. (1) The legal fees payable by the insured person or the insurer for the following matters may be awarded:

1. For all services performed before an arbitration, appeal, variation or revocation hearing.

2. For the preparation for an arbitration, appeal, variation or revocation hearing.

3. For attendance at an arbitration, appeal, variation or revocation hearing.

4. For services subsequent to an arbitration, appeal, variation or revocation hearing.

(2) The number of hours for which legal fees may be awarded shall be determined by the arbitrator, having regard to the criteria set out in subsection 12 (2) of this Regulation.

(3) The maximum amount that may be awarded for legal fees is the amount calculated using the hourly rates set out in the Dispute Resolution Practice Code published by the Ontario Insurance Commission, as it may be amended from time to time.

3.1 (1) The agent's fees payable by the insured person or the insurer for the following matters may be awarded:

1. For the preparation for an arbitration, appeal, variation or revocation hearing.

2. For attendance at an arbitration, appeal, variation or revocation hearing.

3. For services subsequent to an arbitration, appeal, variation or revocation hearing.

(2) The maximum amount that may be awarded for agent's fees is the amount calculated using the hourly rates set out in the Dispute Resolution Practice Code published by the Ontario Insurance Commission, as it may be amended from time to time.

4. The amount of the following disbursements made by or on behalf of the insured person or the insurer may be awarded:

1. For long distance telephone, facsimile and other telecommunication charges.

2. For typing, printing and reproducing copies of documents.

3. For the delivery, by mail or courier, of items relating to the arbitration, appeal, variation or revocation hearing.

4. For other out-of-pocket expenses incurred in furtherance of the arbitration, appeal, variation or revocation hearing.

5. Any applicable taxes paid in respect of the expenses referred to in this section.

5. (1) The amount of the following witness fees paid by or on behalf of the insured person or the insurer may be awarded:

1. For the attendance of witnesses, in accordance with subsection (2).

2. For the attendance of an expert witness who gives opinion evidence at the arbitration or hearing or whose attendance is necessary, in accordance with subsection (3).

3. For a report prepared by an expert, provided to the other parties to the arbitration or hearing and necessary for the conduct of the arbitration or hearing, in accordance with subsection (4).

(2) The maximum amount that may be awarded for the attendance of a witness is the amount of the attendance allowance for the witness that may be allowed under Rule 58.05 of the rules of court as a disbursement.

(3) The maximum amount that may be awarded for the attendance of an expert witness is $200 per hour of attendance, up to a maximum of $1,600 per day.

(4) The amount of the expenses paid by or on behalf of the insured person or the insurer to an expert witness for preparation for a hearing at which the witness testifies may be awarded, to a maximum of $500.

(5) The amount of the expenses paid by or on behalf of the insured person or the insurer to an expert for the preparation of a report may be awarded, to a maximum of $1,500.

6. (1) The amount of the following expenses paid by or on behalf of the insured person, the insured person's lawyer or agent, the insured person's attendant, if one is required, or the insurer's lawyer or agent may be awarded:

1. For travelling expenses, in accordance with subsection (2).

2. For overnight accommodation and meals, in accordance with subsection (3).

(2) The maximum amount of travelling expenses that may be awarded for a person,

(a) for an arbitration or a hearing that takes place in the municipality in which the person resides is the amount incurred by the person for each day of his or her necessary attendance at the arbitration or hearing;

(b) for an arbitration or a hearing that takes place outside the municipality in which the person resides and within 300 kilometres of his or her residence is the lesser of,

(i) 30 cents per kilometre for one return trip between the person's residence and the place in which the arbitration or hearing takes place, or

(ii) the amount incurred by the person;

(c) for an arbitration or a hearing that takes place 300 or more kilometres from the person's residence is the lesser of,

(i) the amount of the return economy airfare for the person plus 30 cents per kilometre for one return trip between his or her residence and the airport and for one return trip between the airport and the place of the arbitration or hearing, or

(ii) the amount incurred by the person.

(3) The maximum amount that may be awarded for overnight expenses and meals is $150 per night for each overnight stay required for the person. R.R.O. 1990, Reg. 664, Schedule.

SECTION G

FORMS

Forms

Form A	Application for Mediation
Form B	Application for Arbitration
Form C	Agreement to Neutral Evaluation at the Commission (Fax-Back Form)
Form D	Response by Insurer to an Application for Arbitration
Form E	Statement of Service
Form F	Reply by the Applicant for Arbitration
Form G	Joint Statement for Neutral Evaluation at the Commission (Fax-Back Form)
Form H	Notice of Appeal
Form I	Response to Appeal
Form J	Reply by the Appellant
Form K	Application for Intervention
Form L	Application for Variation/Revocation
Form M	Response to the Application for Variation/Revocation
Form N	Reply by the Applicant in a Variation/Revocation
Form O	Summons to Witness
Form P	Affidavit of Service for a Summons

Ontario Insurance Commission

Commission des assurances de l'Ontario

Application for Mediation

Use this application form when you have a dispute about whether the insured person qualifies for benefits under the Statutory Accident Benefits Schedule ("SABS") and how much those benefits should be. Mediation is an informal process in which a neutral third party (the mediator) helps the parties resolve the issues in dispute. The mediator works with the parties to find resolutions that are acceptable to everyone involved. There is no cost for mediation. The benefits that can be mediated are described in this booklet.

Before filing an application for mediation, the insured person and the insurance company, or their representatives, should contact each other to identify the issues in dispute, clarify the facts, exchange documents relevant to the dispute and discuss settlement. You are expected to take part personally in the mediation process and to be available during the 60-day mediation period.

After you complete the application, return it to the Ontario Insurance Commission at the address below.

If you have any questions about this application, or want more information, please contact:

Mediation Unit
Dispute Resolution Group
Ontario Insurance Commission
5160 Yonge Street, Box 85
North York ON M2N 6L9
In Toronto: (416) 250-6714, extension 7210
Toll Free: 1-800-517-2332, extension 7210
Fax: (416) 590-7077
Mediation Hotline (416) 590-7210

Personal information requested on this form is collected under the authority of the *Insurance Act* R.S.O. 1990, c.I.8 as amended. This information will be used in the dispute resolution process for statutory accident benefits. This information will be available to all parties to the mediation. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group of the Ontario Insurance Commission at the address above.

Ce formulaire est également disponible en français.

DR-14 (NOV-96)

How to Complete the Application

Please print. Read the instructions carefully when completing the application. To complete the application more easily, remove the section you are filling out and place it beside the relevant instructions.

Section 1

All applicants must complete Section 1 no matter when the accident occurred.

General Information Please answer all five questions. Please note that if you prefer a language other than English or French, it is up to you to make arrangements and pay the cost for your own translator.

Insured Person For the purposes of this application, an insured person is any person making a claim for statutory accident benefits to an insurance company. It is not necessarily the policyholder. Fill in the name and address of the insured person and provide telephone numbers so that we can contact the insured person without delay to discuss the dispute. Provide the details for questions 1 to 4, as required. A minor is anyone under the age of 18.

Insured Person's Representative If the insured person will be represented in mediation by someone else, fill in the name, title, firm name, address and telephone numbers so that we can contact the representative to discuss the dispute. Please include your file reference number, if any. Complete the question concerning the relationship of the representative to the insured person. **The representative must be authorized to settle the dispute on behalf of the insured person.**

Insurance Company Fill in the full name of the insurance company and the person you have been dealing with at the insurance company. Please provide the name of the policyholder, the policy number and the claim number.

Insurance Company's Representative If you are filing on behalf of the insured person, please leave this blank. However, if you are the insurer, please provide the name of the insurance company's repesentative, the representative's title, firm name, address, telephone numbers and file reference number. **The insurance company's representative must be authorized to settle the dispute on behalf of the insurance company.**

Signature and Certification All applicants must sign and date the bottom of Section 1. We may not accept an application unless it is signed by the insured person, the insurance company or a representative. Please read the declaration before signing. After completing the application, make a copy for yourself and send the original to the Dispute Resolution Group at the Ontario Insurance Commission. The address is on the front page of this application. You should attach a copy of any information about your dispute (for example, the insurance company's written explanation of why they denied the benefit, doctor's reports, tax returns and financial statements).

Sections 2,3,4

You need to complete only one of sections 2, 3 or 4.

- If your accident date was on or after November 1, 1996 - fill out section 2 (discard sections 3 and 4).
- If your accident date was on or between January 1, 1994 and October 31, 1996 - fill out section 3 (discard sections 2 and 4).
- If your accident date was on or between June 22, 1990 and December 31, 1993 - fill out section 4 (discard sections 2 and 3).

The sample on the next page shows what kind of information should be filled in the boxes.

DR-14 (NOV-96)

SAMPLE

Section 2

Complete Section 2 ONLY if the accident occurred on or after November 1, 1996.

Insurer Medical Examination and Designated Assessment Centre Information

Please answer the questions about Insurer Medical Examinations (IME) and Designated Assessment Centre (DAC) assessments. In some cases, mediation cannot take place unless insured persons have made themselves reasonably available for an IME or a DAC assessment.

Description of Dispute

Mark the box beside the benefits you are disputing. Please refer to "Available Benefits" in this booklet for a description of the types of statutory accident benefits available. Give the details of the dispute and state the amount that is in dispute, if possible. **Be as specific as possible when you are explaining your reasons for mediation.** List the details of each claim separately. Describe what was claimed, what was paid, what was denied and when. If you need more space, attach additional sheets.

Here are some examples of how to complete this part of the application.

Weekly Benefits ☑

Which Weekly Benefit are you disputing?
income replacement ☑ non-earner ☐

What are you disputing?
initial entitlement to benefits ☐ length of time benefits were paid ☑ amount of benefits paid ☐
overpayment of benefits ☐ entitlement to benefits past 104 weeks ☐ other ☐ _____

If the insured person received Weekly Benefits, please indicate how much was received per week and for what time period: $300.00 per week from Jan. 8, 1997 to May 14, 1997

What is in dispute? I remain unable to return to work. I am unable to perform the physical requirements of my job. I am enclosing the doctor's report and the insurance company's notice terminating benefits.

Medical Benefits ☑

Amount in dispute? $350.00 ($35.00/week for 10 weeks)

What is in dispute? My doctor says that I need chiropractic treatment. I have enclosed the treatment plan sent to the insurance company that says that I need another 8 to 10 weeks of treatments. My insurance company denied my claim on May 29, 1997. I have been assessed by a Designated Assessment Centre, but I disagree with their opinion.

Interest ☑

Amount in dispute? 2 % per month

What is in dispute? My insurance company hasn't paid my weekly benefits since May 14, 1997 and I claim interest on the money that they owe me.

DR-14 (NOV-96)

Mediation of Benefits

If you are applying for mediation, you must file:

- a completed Application for Mediation, describing the issues in disputes;
- a copy of the insurance company's written explanation of why they denied the benefit, if any; and
- **A COPY OF ALL AVAILABLE DOCUMENTS THAT YOU INTEND TO REFER TO IN THE MEDIATION**

Available Benefits

The types of benefits available, the minimum and maximum available and the rules to qualify for benefits may be different depending on when the accident took place.

For accidents that occurred on or after November 1, 1996, the benefits available are:

Income Replacement Benefits pay the insured person for lost income.

Non-Earner Benefits pay insured persons if they suffer a complete inability to carry on a normal life and they do not qualify for income replacement or caregiver benefits.

Caregiver Benefits pay insured persons for some expense incurred if they cannot continue as the main caregiver for a member of their household who is under 16 years of age or who is over 16 years of age and who requries care because of a physical mental incapacity.

Medical Benefits pay for reasonable medical expenses required because of the insured person's injuries. These are expenses that are not covered by any other medical coverage plan such as OHIP or supplementary insurance plans at the insured person's workplace.

Rehabilitation Benefits pay for reasonable rehabilitation expenses that are required because of the insured person's injuries and are not covered by any other insurance plan.

Attendant Care Benefits pay insured persons for the expense of an aide or attendant or services provided by a long term care facility.

Case Manager Services Benefits pay for reasonable expenses related to coordination of goods and services if the insured person sustained a catastrophic impairment as a result of the accident.

Other Expenses (Compensation for other pecuniary losses) pay for other reasonable expenses such as the cost of visiting an insured person during treatment or recovery. It also pays for home maintenance and housekeeping services, repairing or replacing items lost or damaged in the accident and lost educational expenses.

Death Benefits pay money to survivors of a person who dies as a result of the accident.

Funeral Expenses pay for funeral expenses.

For accidents that occurred between January 1, 1994 and October 31, 1996 inclusive, the benefits available are:

Income Replacement Benefits pay the insured person for lost income.

Education Disability Benefits pay insured persons if they are unable to continue their education or to carry out their normal daily activities. It also covers insured persons who completed their education but are unable to get a job that matches their education or training.

Caregiver Benefits pay insured persons if they cannot continue as the main caregiver for a member of their household who is under 16 years of age or who is over 16 years of age and suffers from a disability. It also covers insured persons who cannot carry on their normal daily activities.

Loss of Earning Capacity Benefits replace the above weekly benefits after two years. It is for insured persons who have a long-term reduction in their ability to earn income as a result of the accident.

Other Disability Benefits pay insured persons if they cannot carry out their normal daily activities and they do not qualify for a Weekly Income Replacement Benefit, Education Disability Benefit or Caregiver Benefit.

Supplementary Medical Benefits pay for reasonable medical expenses required because of the insured person's injuries. These are expenses that are not covered by any other medical coverage plan such as OHIP or supplementary insurance plans at the insured person's workplace.

Available Benefits (cont'd)

For accidents that occurred between January 1, 1994 and October 31, 1996 inclusive, the benefits available are: (cont'd)

Rehabilitation Benefits pay for reasonable rehabilitation expenses that are required because of the insured person's injuries and are not covered by any other insurance plan.

Attendant Care Benefits pay insured persons for the expense of an aide or attendant.

Other Expenses (Compensation for other pecuniary losses) pay for other reasonable expenses such as the cost of visiting an insured person during treatment or recovery. It also pays for care for dependents, home maintenance and housekeeping services and repairing or replacing items lost or damaged in the accident.

Death Benefits pay money to survivors of a person who dies as a result of the accident.

Funeral Expenses pay for funeral expenses.

For accidents that occurred between June 22, 1990 and December 31, 1993 inclusive, the benefits available are:

Weekly Benefits pay insured persons for lost income. It also covers insured persons who cannot carry out their normal daily activities.

Child Care Benefits pay insured persons if they cannot continue as the main caregiver for a member of their household who is under 16 years of age or who is over 16 years of age and suffers from a disability.

Supplementary Medical and Rehabilitation Benefits pay for reasonable medical and rehabilitation expenses required because of the insured person's injuries. These are expenses that are not covered by any other medical coverage plan such as OHIP or supplementary insurance plans at the insured person's workplace.

Care Benefits pay insured persons for the expense of an aide or attendant.

Death Benefits pay money to survivors of a person who dies as a result of the accident.

Funeral Expenses pay for funeral expenses.

Sample

Ontario Insurance Commission / Commission des assurances de l'Ontario

Application for Mediation

If the accident occurred on or after November 1, 1996, please complete sections 1 and 2. If the accident occurred between January 1, 1994 and October 31,1996 inclusive, please complete sections 1 and 3. If the accident occurred between June 22, 1990 and December 31, 1993 inclusive, please complete sections 1 and 4. **Please print.**

SECTION 1 *All applicants must complete this section*

General Information

1. What was the date of the accident?
2. Who is making this application? applicant ☐ applicant's representative ☐ insurance company ☐ insurance company's representative ☐
3. Have you applied for mediation before? Yes ☐ No ☐
4. Language preferred: English ☐ French ☐ Other ☐
5. Have you contacted the other party and tried to settle the dispute before applying for mediation? Yes ☐ No ☐

Applicant

Mr. ☐ Mrs. ☐ Ms. ☐ Last Name | First Name | Middle Initial

Birth Date: Month / Day / Year | Street Address

City | Province | Postal Code

Home Phone No. ( ) | Work Phone No. ( ) | Fax No. ( )

1. What is the best way to reach you? telephone ☐ mail ☐ fax ☐ through my representative ☐
2. Where is the best place to reach you? home ☐ work ☐ other ☐
3. When is the best time to reach you? Days of Week/Time of Day a.m./p.m.
4. Is the insured person under a legal disability (a minor or mentally incapable)? Yes ☐ No ☐

Applicant's Representative

Mr ☐ Mrs. ☐ Ms. ☐ Last Name | First Name

Title | Firm Name

Street Address

City | Province | Postal Code

( ) | ( )

What is the relationship to the insured person? lawyer ☐ parent ☐ executor/administrator/trustee ☐ spouse ☐ guardian ☐ other ☐

Insurance Company

Insurance Company

Policyholder | Claims Representative

Policy No | Claim No.

Insurance Company's Representative

Mr ☐ Mrs ☐ Ms. ☐ Last Name | First Name

Title | Firm Name

Street Address

City | Province | Postal Code

File Reference No. | Work Phone No. ( ) | Fax No. ( )

Signature and Certification

I certify that all information in this application is true and complete. I authorize the insurance company to release all medical reports and information relating to the issues in dispute to the Mediation Unit of the Ontario Insurance Commission. I realize that copies of all information filed with this application will be given to the other party in this dispute.

Name (Please print) | Signature X

Title | Date

DR-14 (NOV-96)

SECTION 2 *Complete this section ONLY for accidents that occurred on or after November 1, 1996*

Insurer Medical Examination and Designated Assessment Centre Information

1 Was the insured person asked by the insurance company to attend an Insurer Examination relating to any of the issues in dispute? No ☐ Yes ☐ If yes, did the insured person attend? No ☐ Yes ☐

2.a) Was the insured person asked by the insurance company to attend an assessment at a Designated Assessment Centre relating to any of the issues in dispute? No ☐ Yes ☐ If yes, did the insured person attend? No ☐ Yes ☐

b) What was the assessment relating to? (Mark the box beside the appropriate benefit and fill in the name and address of the DAC attended. If more than one DAC was attended, attach extra sheets.)

medical benefits ☐ rehabilitation benefits ☐
attendant care benefits ☐ determination of catastrophic impairment ☐

3. Did the insured person ask to attend an assessment at a Designated Assessment Centre relating to any of the issues in dispute? No ☐ Yes ☐ If yes, was the assessment relating to: (Mark the box beside the benefit and fill in the name and address of the DAC attended. If more than one DAC was attended, attach extra sheets.)

disability benefits (income replacement, non-earner or caregiver) ☐ disability benefits past 104 weeks of accident (income replacement or caregiver) ☐
determination of catastrophic impairment ☐

Description of Dispute

Please read the instructions before completing this section. Mark the boxes beside all benefits in dispute. If there is more than one amount in dispute for a particular benefit, please give all amounts in the details box.

Weekly Benefits ☐

Which Weekly Benefit are you disputing?
income replacement ☐ non-earner ☐

What are you disputing?
initial entitlement to benefits ☐ length of time benefits were paid ☐ amount of benefits paid ☐
overpayment of benefits ☐ entitlement to benefits past 104 weeks ☐ other ☐ _____

If the insured person received Weekly Benefits, please indicate how much was received per week and for what time period: $ _____ per week from _____ to _____

What is in dispute?

Caregiver Benefit ☐

Amount in dispute? $ _____

What is in dispute?

Medical Benefits ☐

Amount in dispute? $ _____

What is in dispute?

DR-14 (NOV-96)

Form A

Application for Mediation

If you need more space to describe the dispute, please attach additional sheets. After completing this section, make sure that you have signed the application at the bottom of Section 1. Return Sections 1 and 2 of the application plus any additional sheets to the Ontario Insurance Commission at the address on the front page.

Rehabilitation Benefits ☐

Amount in dispute? $

What is in dispute?

Attendant Care Benefits ☐

Amount in dispute? $

What is in dispute?

Case Manager Services Benefits ☐

Amount in dispute? $

What is in dispute?

Death Benefits and/or Funeral Expenses ☐

Amount in dispute? $

What is in dispute?

Other Expenses ☐

What are you disputing?

- expenses of visitors ☐
- damage to clothing, etc. ☐
- lost educational expenses ☐
- housekeeping & home maintenance ☐
- cost of examinations ☐

What is in dispute?

Interest ☐

Amount in dispute? $

What is in dispute?

Other Disputes ☐

Amount in dispute? $

What is in dispute?

DR-14 (NOV-96)

Form A

Application for Mediation

SECTION 3 *Complete this section ONLY for accidents that occurred on or between January 1, 1994 and October 31, 1996*

Insurer Medical Examination and Designated Assessment Centre Information

1. Was the insured person asked by the insurance company to attend an Insurer Medical Examination relating to any of the issues in dispute? No ☐ Yes ☐ If yes, did the insured person attend? No ☐ Yes ☐

2. a) Was the insured person asked by the insurance company to attend an assessment at a Designated Assessment Centre relating to any of the issues in dispute? No ☐ Yes ☐ If yes, did the insured person attend? No ☐ Yes ☐

b) What was the assessment relating to? (Mark the box beside the appropriate benefit and fill in the name and address of the DAC attended. If more than one DAC was attended, attach extra sheets.)

supplementary medical benefits ☐ rehabilitation benefits ☐
attendant care benefits ☐ loss of earning capacity benefits ☐

3. Did the insured person ask to attend an assessment at a Designated Assessment Centre relating to any of the issues in dispute? No ☐ Yes ☐ If yes, was the assessment relating to: (Mark the box beside the benefit and fill in the name and address of the DAC attended. If more than one DAC was attended, attach extra sheets).

weekly disability benefits ☐ loss of earning capacity benefits ☐

Description of Dispute

Please read the instructions before completing this section. Mark the boxes beside all benefits in dispute. If there is more than one amount in dispute for a particular benefit, please give all amounts in the details box.

Weekly Benefits ☐

Which Weekly Benefit are you disputing?
income replacement ☐ education disability ☐ caregiver ☐ other disability ☐

What are you disputing?
initial entitlement to benefits ☐ length of time benefits were paid ☐ amount of benefits paid ☐
overpayment of benefits ☐ entitlement to benefits past 104 weeks ☐ other ☐ _____

If the insured person received Weekly Benefits, please indicate how much was received per week and for what time period: $ _____ per week from _____ to _____

What is in dispute?

Education Disability Benefits (Lump Sum Benefit) ☐

Amount in dispute? $ _____

What is in dispute?

DR-14 (NOV-96)

If you need more space to describe the dispute, please attach additional sheets. After completing this section, make sure that you have signed the application at the bottom of Section 1. Return Sections 1 and 3 of the application plus any additional sheets to the Ontario Insurance Commission at the address on the front page.

Medical Benefits ☐
Amount in dispute? $
What is in dispute?

Rehabilitation Benefits ☐
Amount in dispute? $
What is in dispute?

Attendant Care Benefits ☐
Amount in dispute? $
What is in dispute?

Death Benefits ☐
Amount in dispute? $
What is in dispute?

Funeral Expenses ☐
Amount in dispute? $
What is in dispute?

Loss of Earning Capacity Benefits ☐
Did you receive a Loss of Earning Capacity Benefits offer from the insurer?
No ☐ claiming entitlement to Loss of Earning Capacity Benefits
Yes ☐ what part(s) of the offer are you disputing?
pre-accident earning capacity ☐ residual earning capacity ☐
What is in dispute?

Interest ☐
Amount in dispute? $
What is in dispute?

Other Disputes ☐
Amount in dispute? $
What is in dispute?

DR-14 (NOV-96)

SECTION 4 *Complete this section ONLY for accidents that occurred on or between June 22, 1990 and December 31, 1993*

Insurer Medical Examination Information

Was the insured person asked by the insurance company to attend an Insurer Medical Examination relating to any of the issues in Dispute? No ☐ Yes ☐ If yes, did the insured person attend? No ☐ Yes ☐

Description of Dispute

Please read the instructions before completing this section. Mark the boxes beside all benefits in dispute. If there is more than one amount in dispute for a particular benefit, please give all amounts in the details box.

Weekly Benefits ☐

What are you disputing?
length of time benefits were paid ☐ amount of benefits paid ☐ other ☐ _____

If the insured person received Weekly Benefits, please indicate how much was received per week and for what time period: $ _____ per week from _____ to _____

What is in dispute?

Weekly Childcare Benefits ☐

What are you disputing?
length of time benefits were paid ☐ amount of benefits paid ☐ other ☐ _____

If the insured person received Weekly Childcare Benefits, please indicate how much was received per week and for what time period: $ _____ per week from _____ to _____

What is in dispute?

Supplementary Medical/ Rehabilitation Benefits ☐ Amount in dispute? $ _____

What is in dispute?

Care Benefits ☐ Amount in dispute? $ _____

What is in dispute?

DR-14 (NOV-96)

If you need more space to describe the dispute, please attach additional sheets. After completing this section, make sure that you have signed the application at the bottom of Section 1. Return Sections 1 and 4 of the application plus any additional sheets to the Ontario Insurance Commission at the address on the front page.

Death Benefits ☐ Amount in dispute? $

What is in dispute?

Funeral Benefits ☐ Amount in dispute? $

What is in dispute?

Interest ☐ Amount in dispute? $

What is in dispute?

Other Disputes ☐ Amount in dispute? $

What is in dispute?

DR-14 (NOV-96)

Ontario Insurance Commission

Commission des assurances de l'Ontario

Application for Arbitration

Use this form to apply for arbitration of disputes. You can apply for arbitration only if the specific issues in dispute have not been resolved through mediation. **You may also use this form to apply for Neutral Evaluation.**

After you complete the application, **keep one copy** for yourself and return **two copies** of the completed application form, along with relevant documents and the filing fee to the Ontario Insurance Commission (OIC) at the address below.

Personal information requested on this form is collected under the authority of the *Insurance Act* R.S.O. 1990, c.I.8 as amended. This information, including documents submitted with this application, will be used in the dispute resolution process for accident benefits. This information will be available to all parties to the proceeding. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group, at the address below.

You must enclose an application fee of **$100**. Make your cheque or money order payable to the **Minister of Finance**. Cheques made out to the OIC cannot be accepted and will be returned. Failure to pay the application fee will result in the OIC returning your application to you.

If you have any questions about this application, or want more information, contact:

Arbitration Unit
Dispute Resolution Group
Ontario Insurance Commission
5160 Yonge Street, 14th Floor, Box 85
North York ON M2N 6L9
In Toronto: (416) 250-6714, extension 7202
Toll Free: 1-800-517-2332, extension 7202
Fax: (416) 590-8462
Arbitration Hotline (416) 590-7202

Ce formulaire est également disponible en français.

DR-15 (NOV-96)

Application for Arbitration

Applying for Arbitration.....

For a complete set of the rules about Arbitration and Neutral Evaluation, refer to the Dispute Resolution Practice Code.

How to Complete the Form.....

Applicant

Fill in your name, address and phone numbers, and tell us the best place to reach you. Be sure to fill in the mediation file number. You can find the mediation file number on the front of the Mediator's Report.

Applicant's Representative

You may choose to have someone represent you. Although many people are represented by a lawyer during arbitration, a lawyer is not required. If you have a representative, fill in the name, address and phone number of your representative. If it is a firm, please give the name of the firm in the box provided. **If your representative is NOT a lawyer, please provide written confirmation that the representative is authorized to act for you during the arbitration and can settle the dispute on your behalf. A minor (a person under the age of 18) or a person who is mentally incapable, must have a representative.**

Insurance Company

Fill out the name of the insurance company and a contact or representative if known. Please provide the name of the policyholder and the policy number.

Neutral Evaluation: NEW

Neutral Evaluation may be appropriate for your case if the issues in dispute are clearly defined. **Neutral Evaluation is an assessment of the issues in dispute by an experienced evaluator who will provide a non-binding opinion concerning the probable outcome if your case proceeds to court or arbitration. If your dispute has been referred to Neutral Evaluation by the mediator, please check off the appropriate box on the application.**

Otherwise, if you wish to obtain Neutral Evaluation through the OIC, you must contact your insurance company. Both sides must agree to neutral evaluation and both sides must confirm that ALL RELEVANT DOCUMENTS AND REPORTS REQUIRED FOR A DETERMINATION OF THE ISSUES HAVE BEEN OBTAINED AND EXCHANGED.

Arbitration Hearing

Please provide details concerning the arrangements you will require for an arbitration hearing. In most cases, both sides of a dispute want an oral hearing. However, in simple disputes where no witnesses will be called and little evidence will be filed, it is possible to speed up the arbitration process by waiving the right to an oral hearing. Both sides must agree before this will be done. If both sides agree, the arbitrator will decide the case based on the written materials submitted. **If you need an interpreter or other special services (such as sign language or wheelchair access), please give details in this section.** Most arbitration hearings are held at the Ontario Insurance Commission offices in North York. However, if you live outside the Greater Metropolitan Toronto area, arrangements can be made to conduct a hearing in a location near your home.

Signature and Certification

Sign and date the form and return it to the Arbitration Unit of the Dispute Resolution Group at the Ontario Insurance Commission. Be sure to enclose a cheque or money order for $100 payable to the **Minister of Finance.**
NOTE: Your application may be rejected if these steps have not been completed as requested.

Issues in Dispute

Please check all of the benefits you want arbitrated. Check the benefits that are still being disputed (as they appear on the Mediator's Report). **You cannot add new issues at this stage unless the other side agrees.**
Make sure you fill in the section that corresponds to the date of your accident.

DR-15 (NOV-96)

Steps in the Arbitration Process.....

Step 1:
Return the following items to the Arbitration Unit of the Ontario Insurance Commission (OIC). The full address is on the front of the this form.

- Two copies of the completed Application for Arbitration, signed and dated,
- Copy of the Mediator's Report (if available),
- Copy of Report of Neutral Evaluator if neutral evaluation has taken place.
- Any information about your dispute that is relevant (i.e., doctor's reports, tax receipts or financial statements). **Send copies only - keep originals of all your documents,**
- The **$100** filing fee, payable to the **Minister of Finance.**

Failure to comply with all these instructions will result in your application being returned to you.

Step 2:
The OIC will send a copy of your *Application* to the insurance company. If you and the insurer jointly agree to refer your dispute to Neutral Evaluation at the OIC, the Commission will set a date for the evaluation. If your case does not settle after the Neutral Evaluation, you will move directly to **Step 6** below.

Step 3:
If your case is not referred to Neutral Evalution, the insurance company must file a *Response to an Application* with the OIC within 20 days of their receipt of your *Application for Arbitration*. The *Response* will state the company's position on the dispute and may raise new issues which were not resolved in mediation. You will get a copy of the *Insurer's Response to an Application for Arbitration*.

Step 4:
You will have an opportunity to reply to what the insurance company has said. If you wish to reply, you can use the *Reply by the Applicant* form that is available from the OIC. You will have 10 days from the day you receive the insurance company's *Response* to reply. Send the insurance company and the OIC a copy of your reply.

Step 5:
The OIC will set a date for a pre-hearing discussion with an arbitrator, before you have a hearing. You are requested to produce and exchange all relevant documents and reports **before** the pre-hearing discussion. At the pre-hearing discussion, you and the insurance company will discuss the issues with an arbitrator and make arrangements for the hearing.

Step 6:
If you have not settled the dispute after Neutral Evaluation or a pre-hearing discussion, a hearing will be scheduled. After the hearing, the written order of the arbitrator will be sent to you and the insurance company.

Note:

You may settle your dispute with the insurance company directly at any time during the arbitration process.

Ontario Insurance Commission / Commission des assurances de l'Ontario

Application for Arbitration

SECTION 1 *All applicants must complete this section* — *General Information*

General Information

1. What was the date of the accident? Month / Day / Year
2. Who is making this application? applicant ☐ applicant's representative ☐
3. What is the applicant's date of birth? Month / Day / Year
4. Language preferred: English ☐ French ☐ Other ☐ _____
5. Have you contacted the other party and tried to settle the dispute since mediation? Yes ☐ No ☐
6. Provide mediation file number M- _____ Have you attached a copy of the mediator's report? Yes ☐ No ☐

Applicant

Mr ☐ Mrs ☐ Ms ☐ Last Name | First Name | Middle Initial

Street Address

City | Province | Postal Code

Home Phone No. ( ) | Work Phone No. ( ) | Fax Number ( )

1. What is the best way to reach you? telephone ☐ mail ☐ fax ☐ through my representative ☐
2. Where is the best place to reach you? home ☐ work ☐ other ☐ _____
3. When is the best time to reach you? Days of Week/Time of Day a.m./p.m.
4. Is the insured person under a legal disability (a minor or mentally incapable)? Yes ☐ No ☐
   If yes, has a family member or legal guardian been appointed? Yes ☐ No ☐

Applicant's Representative

Mr ☐ Mrs ☐ Ms ☐ Last Name | First Name

Title | Firm Name

Street Address

City | Province | Postal Code

File Reference No | Work Phone No. ( ) | Fax No. ( )

What is the relationship to the insured person? lawyer ☐ parent ☐ executor/administrator/trustee ☐
spouse ☐ legal guardian ☐ other ☐ _____

Insurance Company

Insurance Company

Policyholder | Claims Representative

Policy No. | Claim No.

DR-15 (NOV-96)

SECTION 1 *All applicants must complete this section (cont'd)* **General Information**

Neutral Evaluation

1. Are any issues relating to this accident still in mediation? No ☐ Yes ☐ If yes, what is/are the mediation file number(s)? M- _____
2. Does the mediator's report refer issues in dispute for neutral evaluation? No ☐ Yes ☐
3. Have you referred any issues in dispute to a neutral evaluator appointed by the Director of Arbitration ? No ☐ Yes ☐
4. Did the neutral evaluator issue a written report? No ☐ Yes ☐
   If yes, attach a copy of the report
5. Do you want neutral evaluation through the OIC? No ☐ Yes ☐
   If yes, do you certify that all documents or reports listed in the **Report of Mediator** have been exchanged and that no other documents are required for the purpose of evaluating the issues in dispute? Yes ☐

Signature _____

Arbitration Hearing

1. Do you wish to waive your right to an oral arbitration hearing? No ☐ Yes ☐
2. Do you wish the arbitration hearing to be conducted in French? No ☐ Yes ☐
3. Will you require the services of an interpreter at the arbitration hearing? No ☐ Yes ☐
   If yes, what language? _____
4. Do you require other special services such as wheelchair access? No ☐ Yes ☐
   If yes, please describe: _____
5. Do you require the hearing to be held outside the Greater Metropolitan Toronto Area? No ☐ Yes ☐
   If yes, where? _____

Signature and Certification

I certify that all information in this application and attachments are true and complete. I authorize the insurance company to release all medical reports and information relating to the issues in dispute to the Arbitration Unit of the Ontario Insurance Commission. I realize that copies of all information filed with this application will be given to the other party in this

Applicant Name (Please print)	Applicant Signature
	X
Representative Name (Please print)	Representative Signature
	X
Cheque or money order enclosed ☐	Date

DR-15 (NOV-96)

ISSUES IN DISPUTE

The types of benefits available, the minimum and maximum amounts available and the rules to qualify for benefits may be different depending on when your accident took place. Fill in only that section which relates to the date of your accident.

You need to complete only one of sections 2, 3 or 4.

- If your accident date was on or after November 1, 1996 - fill out section 2 (discard sections 3 and 4).
- If your accident date was on or between January 1, 1994 and October 31, 1996 - fill out section 3 (discard sections 2 and 4).
- If your accident date was on or between June 22, 1990 and December 31, 1993 - fill out section 4 (discard sections 2 and 3).

SECTION 2 *Complete this section ONLY for accidents that occurred on or after November 1, 1996*

Description of Dispute

Mark the boxes beside the benefits that were not resolved in mediation and which you now want evaluated or arbitrated. You cannot add new issues after mediation, unless the other side agrees.

Do you have optional benefits? No ☐ Yes ☐

Weekly Benefits ☐ Which weekly benefits are you disputing? income replacement ☐ non-earner ☐

What are you disputing?

initial entitlement to benefits ☐ length of time benefits were paid ☐ amount of weekly benefit ☐

entitlement to benefits past 104 weeks ☐ benefits after age 65 ☐ other ☐ _____

Is the insurance company claiming an overpayment of benefits? No ☐ Yes ☐

Briefly explain why you want arbitration. Refer to disputed issues in mediation report. (Attach additional sheets if necessary.)

Caregiver Benefits ☐ Amount in dispute? $

What are you disputing?

initial entitlement to benefits ☐ length of time benefits were paid ☐ amount of benefit ☐

entitlement to benefits past 104 weeks ☐ other ☐ _____

Briefly explain why you want arbitration. Refer to disputed issues in mediation report. (Attach additional sheets if necessary.)

Does this claim involve "catastrophic impairment"? No ☐ Yes ☐

Medical Benefits ☐ Amount in dispute? $

Rehabilitation Benefits ☐ Amount in dispute? $

Briefly explain why you want arbitration. Refer to disputed issues in mediation report. (Attach additional sheets if necessary.)

DR-15 (NOV-96)

Form B

Application for Arbitration

Attendant Care Benefits ☐ Amount in dispute? $ _____ **Case Manager Services Benefits** ☐ Amount in dispute? _____

Briefly explain why you want arbitration. Refer to disputed issues in mediation report. (Attach additional sheets if necessary.)

Other Expenses ☐ Amount in dispute? $ _____

What are you disputing?

lost educational expenses ☐
expenses of visitors ☐ housekeeping & home maintenance ☐
damage to clothing, etc. ☐ cost of examinations ☐

Briefly explain why you want arbitration. Refer to disputed issues in mediation report. (Attach additional sheets if necessary.)

Death Benefits ☐ Amount in dispute? $ _____ **Funeral Benefits** ☐ Amount in dispute? $ _____

Briefly explain why you want arbitration. Refer to disputed issues in mediation report. (Attach additional sheets if necessary.)

Interest ☐ **Expenses of the Hearing** ☐ **Special Award** ☐

Briefly explain why you want arbitration. Refer to disputed issues in mediation report. (Attach additional sheets if necessary.)

Other Disputes ☐ Amount in dispute? $ _____

Briefly explain why you want arbitration. Refer to disputed issues in mediation report. (Attach additional sheets if necessary.)

DR-15 (NOV-96)

Application for Arbitration

SECTION 3 *Complete this section ONLY for accidents that occurred on or between January 1, 1994 and October 31, 1996, inclusive.*

Description of Dispute **Mark the boxes beside the benefits in dispute that were not resolved in mediation which you now want evaluated or arbitrated. You cannot add new issues after mediation unless the other side agrees.**

Weekly Benefits ☐ Which Weekly Benefit are you disputing?
income replacement ☐ education disability ☐ caregiver ☐ other disability ☐

What are you disputing?
initial entitlement to benefits ☐ length of time benefits were paid ☐ amount of weekly benefits ☐

entitlement to benefits past 104 weeks ☐ benefits after age 65 ☐ other ☐ _____

Do you have a Pre-determined Income from Self-Employment Agreement? No ☐ Yes ☐

Is the insurance company claiming an overpayment of benefits? No ☐ Yes ☐

Briefly explain why you want arbitration. Refer to disputed issues in mediation report. (Attach additional sheets if necessary.)

Loss of Earning Capacity Benefits ☐ Did you receive a Loss of Earning Capacity Benefits offer from the insurer? No ☐ claiming entitlement to Loss of Earning Capacity Benefits
Yes ☐ what part(s) of the offer are you disputing?
Pre-accident earning capacity ☐ Residual earning capacity ☐

Briefly explain why you want arbitration. Refer to disputed issues in mediation report. (Attach additional sheets if necessary.)

Education Disability Benefits (Lump Sum Benefit) ☐ Amount in dispute? $

Briefly explain why you want arbitration. Refer to disputed issues in mediation report. (Attach additional sheets if necessary.)

Medical Benefits ☐ Amount in dispute? $ ☐ **Rehabilitation Benefits** Amount in dispute? $

Briefly explain why you want arbitration. Refer to disputed issues in mediation report. (Attach additional sheets if necessary.)

DR-15 (NOV-96)

Form B

Application for Arbitration

Attendant Care Benefits ☐ Amount in dispute? $

Compensation for other Pecuniary Losses ☐ Amount in dispute? $

Expenses of Visitors ☐ Damage to Clothing, Glasses, etc. ☐
Dependant Care Expenses ☐ Housekeeping & Home Maintenance ☐
Cost of Examination ☐

Briefly explain why you want arbitration. Refer to disputed issues in mediation report (Attach additional sheets if necessary.)

Death Benefits ☐ Amount in dispute? $

Funeral Benefits ☐ Amount in dispute? $

Briefly explain why you want arbitration. Refer to disputed issues in mediation report (Attach additional sheets if necessary.)

Interest ☐

Expenses of the Hearing ☐

Special Award ☐

Briefly explain why you want arbitration. Refer to disputed issues in mediation report (Attach additional sheets if necessary.)

Other Disputes ☐ Amount in dispute? $

Briefly explain why you want arbitration. Refer to disputed issues in mediation report (Attach additional sheets if necessary.)

DR-15 (NOV-96)

SECTION 4 *Complete this section ONLY for accidents that occurred on or between June 22, 1990 and December 31, 1993, inclusive*

Description of Dispute

Mark the boxes beside the benefits in dispute that were not resolved in mediation which you now want evaluated or arbitrated. You cannot add new issues after mediation unless the other side agrees.

Do you have Optional Benefits? No ☐ Yes ☐

Weekly Benefits ☐

Which Weekly Benefits are you disputing? employed benefits ☐ benefit if no income ☐

What are you disputing?

initial entitlement to benefits ☐ length of time benefits were paid ☐ amount of weekly benefit ☐

benefits past 156 weeks ☐ Other ☐ _____

Is the insurance company claiming an overpayment of benefits? No ☐ Yes ☐

Briefly explain why you want arbitration. Refer to disputed issues in mediation report. (Attach additional sheets if necessary.)

Childcare Benefits ☐

What are you disputing?

length of time benefits were paid ☐ amount of benefits ☐ other ☐ _____

Amount in Dispute $

Briefly explain why you want arbitration. Refer to disputed issues in mediation report. (Attach additional sheets if necessary.)

Supplementary Medical/ Rehabilitation Benefits ☐

Amount in dispute? $

Care Benefits ☐ Amount in dispute? $

Briefly explain why you want arbitration. Refer to disputed issues in mediation report. (Attach additional sheets if necessary.)

Death Benefits ☐

Amount in dispute? $

Funeral Expenses ☐ Amount in dispute? $

Briefly explain why you want arbitration. Refer to disputed issues in mediation report. (Attach additional sheets if necessary.)

DR-15 (NOV-96)

Interest ☐ Expenses of the Hearing ☐ Special Award ☐

Briefly explain why you want arbitration. Refer to disputed issues in mediation report. (Attach additional sheets if necessary.)

Other Disputes ☐ Amount in dispute? $

Briefly explain why you want arbitration. Refer to disputed issues in mediation report. (Attach additional sheets if necessary.)

Sample

DR-15 (NOV-96)

Ontario Insurance Commission / Commission des assurances de l'Ontario

AGREEMENT TO NEUTRAL EVALUATION
FAX-BACK

THIS CONSENT FAX-BACK MUST BE RECEIVED BY THE OIC ARBITRATION UNIT BY: DATE #1 (5 BUSINESS DAYS AFTER RECEIPT OF PACKAGE), if the insurer chooses to participate in the OIC neutral evaluation process as part of arbitration. If the issuer does not want to participate in OIC neutral evaluation the insurer must complete the Response to an Application for Arbitration.

To: **Mary Jones** **Fax: (416) 590-8462**
OIC Case Administrator

Re: **OIC FILE No A96-00001**
(JOHN SMITH & ABC INSURANCE COMPANY)

Claim No.: **0000001**
Policy No.: **00000087**
Policy Holder: **John Smith**

FROM: Dave Johnson - ADR Coordinator
ABC INSURANCE COMPANY

We consent to a referral of the issues in dispute to a person appointed by the Director for a neutral evaluation at the Ontario Insurance Commission.

We hereby certify that all documents listed in the Report of Mediator have been exchanged or will be exchanged by DATE #2 (30 DAYS AFTER DATE #1) and that no other documents or reports are required for the neutral evaluation.

The person identified below will be available for a neutral evaluation between DATE # 3 (45 days after DATE #1) and DATE #4 (60 days after DATE #1).

THE PERSON HANDLING THIS FILE, WITH BINDING AUTHORITY, ON BEHALF OF THE INSURANCE COMPANY:

_____ _____
(Name of Company Representative) (Title)

( ) _____ ( ) _____
Telephone Number Facsimile Number

Or the Insurance Company's legal representative

_____ _____
(Name) (Law Firm)

( ) _____ ( ) _____
Telephone Number Facsimile Number

SIGNATURE: _____ _____
ADR COORDINATOR DATE

Ontario Insurance Commission / Commission des assurances de l'Ontario

Response by Insurer to an Application for Arbitration

Arbitration File Number

An **Application for Arbitration** has been filed with the Dispute Resolution Group of the Ontario Insurance Commission. Your company is named as a party in this arbitration. A copy of the **Application for Arbitration** is attached. Use this form to respond to the issues raised in the **Application**. You can add new issues which have been mediated but not settled. You must serve a copy of this **Response** on the applicant and provide proof of service to the Commission. This must be done within **20 days** of receiving this document. This **Response** need not be completed if the insurer agrees to the applicant's request for Neutral Evaluation.

Personal information requested on this form is collected under the authority of the *Insurance Act* R.S.O. 1990, c. I.8 as amended. This information, including documents submitted with this form, will be used in the dispute resolution process for accident benefits. This information will be available to all parties to the proceeding. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group, Ontario Insurance Commission.

Applicant

Last Name | First Name | Date of Accident: Month Day Year

Insurance Company

Name

Contact Person

Street Address

City | Province | Postal Code

Phone Number ( ) | Fax Number ( )

Your claim number

Legal Representative

Name

Firm

Street Address

City | Province | Postal Code

Phone Number ( ) | Fax Number ( )

Signature

Name | Title

Date | Signature

DR-16 (NOV-96)

Ce formulaire est également disponible en français.

Sample

Response by Insurer to an Application for Arbitration

SECTION 1 *Complete this section ONLY for accidents that occurred on or after November 1, 1996*

Description of Dispute **Mark all the boxes beside the benefits that were not resolved in mediation and which the insurer wishes to respond to or now wants arbitrated. The insurer can add new issues which have been mediated but not settled.**

Does the applicant have optional benefits? No ☐ Yes ☐

Weekly Benefits ☐

Which weekly benefits are being disputed?
income replacement ☐ non-earner ☐

What is being disputed?
initial entitlement to benefits ☐ length of time benefits were paid ☐ amount of weekly benefits ☐
entitlement to benefits past 104 weeks ☐ benefits after age 65 ☐ other ☐ _____
Is the insurance company claiming an overpayment of benefits No ☐ Yes ☐

Briefly explain your company's position on the issues in dispute. (Attach additional sheets if necessary.)

Caregiver Benefits ☐

Amount in dispute? $

What is being disputed?
initial entitlement to benefits ☐ length of time benefits were paid ☐ amount of benefits ☐
entitlement to benefits past 104 weeks ☐ other ☐ _____

Briefly explain your company's position on the issues in dispute. (Attach additional sheets if necessary.)

Does this claim involve catastrophic impairment? No ☐ Yes ☐

Medical Benefits ☐

Amount in dispute? $

Rehabilitation Benefits ☐

Amount in dispute? $

Briefly explain your company's position on the issues in dispute. (Attach additional sheets if necessary.)

Attendant Care Benefits ☐

Amount in dispute? $

Case Manager Services Benefits ☐

Amount in dispute? $

Briefly explain your company's position on the issues in dispute. (Attach additional sheets if necessary.)

Other Expenses ☐

Amount in dispute? $

What is in dispute?
expenses of visitors ☐ lost educational expenses ☐
damage to clothing, etc. ☐ cost of examinations ☐
housekeeping & home maintenance ☐

Briefly explain your company's position on the issues in dispute. (Attach additional sheets if necessary.)

DR-16 (NOV-96)

Form D

Response by Insurer to an Application for Arbitration

Death Benefits ☐ Amount in dispute? $ **Funeral Benefits** ☐ Amount in dispute? $

Briefly explain your company's position on the issues in dispute. (Attach additional sheets if necessary.)

Interest ☐ **Expenses of the Hearing** ☐ **Special Award** ☐

Briefly explain your company's position on the issues in dispute. (Attach additional sheets if necessary.)

Abuse of Process, Frivolous or Vexatious Proceedings ☐

Briefly explain your company's position on this issue (Attach additional sheets if necessary.)

Claim for Repayment ☐ Amount in dispute? $

Briefly explain your company's position on the issues in dispute. (Attach additional sheets if necessary.)

Other Disputes ☐ Amount in dispute? $

Briefly explain your company's position on the issues in dispute. (Attach additional sheets if necessary.)

Does your company waive the right to an oral hearing? No ☐ **Yes** ☐

DR-16 (NOV-96)

Form D

Response by Insurer to an Application for Arbitration

SECTION 2 *Complete this section ONLY for accidents that occurred on or between January 1, 1994 and October 31, 1996, inclusive.*

Description of Dispute

Mark the boxes beside the benefits that were not resolved in mediation and which the insurer wishes to respond to or now wants arbitrated. The insurer can add new issues which have been mediated but not settled.

Weekly Benefits ☐

Which Weekly Benefits are being disputed?
income replacement ☐ education disability ☐ caregiver ☐ other disability ☐

What is being disputed?
initial entitlement to benefits ☐ length of time benefits were paid ☐ amount of weekly benefit ☐
entitlement to benefits past 104 weeks ☐ benefits after age 65 ☐ other ☐ _____

Does the applicant have a Pre-determined Income from Self-Employment Agreement No ☐ Yes ☐

Is the issue in dispute an overpayment of benefits? No ☐ Yes ☐

Briefly explain your company's position on the issues in dispute. (Attach additional sheets if necessary.)

Loss of Earning Capacity Benefits ☐

Did your company make a Loss of Earning Capacity Benefits offer to the applicant? No ☐ disputing entitlement to Loss of Earning Capacity Benefits
Yes ☐ what part(s) of the offer are being disputed?
Pre-accident earning capacity ☐ Residual earning capacity ☐

Briefly explain your company's position on the issues in dispute. (Attach additional sheets if necessary.)

Education Disability Benefits (Lump Sum Benefit) ☐

Amount in dispute? $

Briefly explain your company's position on the issues in dispute (Attach additional sheets if necessary.)

Medical Benefits ☐

Amount in dispute? $

Rehabilitation Benefits ☐

Amount in dispute? $

Briefly explain your company's position on the issues in dispute (Attach additional sheets if necessary.)

DR-16 (NOV-96)

Form D

Response by Insurer to an Application for Arbitration

Attendant Care Benefits ☐ Amount in dispute? $

Compensation for other Pecuniary Losses ☐ Amount in dispute? $

Expenses of Visitors ☐ Damage to Clothing, Glasses, etc. ☐

Dependant Care Expenses ☐ Housekeeping & Home Maintenance ☐

Cost of Examination ☐

Briefly explain your company's position on the issues in dispute. (Attach additional sheets if necessary.)

Death Benefits ☐ Amount in dispute? $

Funeral Benefits ☐ Amount in dispute? $

Briefly explain your company's position on the issues in dispute. (Attach additional sheets if necessary.)

Interest ☐

Expenses of the Hearing ☐

Special Award ☐

Briefly explain your company's position on the issues in dispute. (Attach additional sheets if necessary.)

Abuse of Process, Frivolous or Vexatious Proceedings ☐

Briefly explain your company's position on this issue. (Attach additional sheets if necessary.)

Claim for Repayment ☐ Amount in dispute? $

Briefly explain your company's position on the issues in dispute. (Attach additional sheets if necessary.)

Other Disputes ☐ Amount in dispute? $

Briefly explain your company's position on the issues in dispute. (Attach additional sheets if necessary.)

Does your company waive the right to an oral hearing? No ☐ Yes ☐

DR-16 (NOV-96)

Form D

Response by Insurer to an Application for Arbitration

SECTION 3 *Complete this section ONLY for accidents that occurred on or between June 22, 1990 and December 31, 1993, inclusive.*

Description of Dispute

Mark all the boxes beside the benefits in dispute that were not resolved in mediation to which the insurer wishes to respond or now wants arbitrated. The insurer can add new issues which have been mediated but not settled.

Does the applicant have optional benefits? No ☐ Yes ☐

Weekly Benefits ☐ Which Weekly Benefit is being disputed?
employed benefits ☐ benefit if no income ☐
What is being disputed?
initial entitlement to benefits ☐ length of time benefits were paid ☐ amount of weekly benefit ☐
benefits past 156 weeks ☐ other ☐ _____

Is the issue in dispute an overpayment of benefits? No ☐ Yes ☐

Briefly explain your company's position on the issues in dispute (Attach additional sheets if necessary)

Childcare Benefits ☐ What is in dispute?
length of time benefits were paid ☐ amount of benefits ☐ other ☐ _____

Amount in Dispute $

Briefly explain your company's position on the issues in dispute. (Attach additional sheets if necessary)

Supplementary Medical/ Rehabilitation Benefits ☐ Amount in dispute? $

Care Benefits ☐ Amount in dispute? $

Briefly explain your company's position on the issues in dispute (Attach additional sheets if necessary)

Death Benefits ☐ Amount in dispute? $

Funeral Expenses ☐ Amount in dispute? $

Briefly explain your company's position on the issues in dispute. (Attach additional sheets if necessary.)

DR-16 (NOV-96)

Form D

Response by Insurer to an Application for Arbitration

Interest ☐ Expenses of the Hearing ☐ Special Award ☐

Briefly explain your company's position on the issues in dispute (Attach additional sheets if necessary.)

Abuse of Process, Frivolous or Vexatious Proceedings ☐

Briefly explain your company's position on the issues in dispute (Attach additional sheets if necessary.)

Claim for Repayment ☐ Amount in dispute? $

Briefly explain your company's position on the issues in dispute (Attach additional sheets if necessary.)

Other Disputes ☐ Amount in dispute? $

Briefly explain your company's position on the issues in dispute. (Attach additional sheets if necessary.)

Does your company waive the right to an oral hearing? No ☐ Yes ☐

DR-16 (NOV-96)

Sample

Ontario
Insurance
Commission

Ontario

Statement of Service

The purpose of this statement is to verify that a copy of a document was delivered to a party. A *Statement of Service* must be completed for every document served and given to the insured person and the insurance company, or their representatives. **Do not use this form where proof of service of a Summons and payment is required to be filed with the Commission.** In this case, you should use an *Affidavit of Service* which is available at the Ontario Insurance Commission.

OIC Case Name and Number

Insured Person

and

Insurance Company

OIC File Number

Who are you?

Your Name

Occupation

Address

Who was served?

Name

Address

What was served?

Arbitration Documents

- ☐ Application for Arbitration
- ☐ Response to an Application for Arbitration
- ☐ Reply by the Applicant for Arbitration
- ☐ Other (please specify below)

Appeal Documents

- ☐ Notice of Appeal
- ☐ Response to Appeal
- ☐ Reply by the Appellant
- ☐ Other (please specify below)

How was it served?

- ☐ Personal delivery
- ☐ Courier (give name of company below)
- ☐ Fax
- ☐ Regular mail
- ☐ Registered mail
- ☐ Other (specify) _____

Name of Service Used

Address Served To

Date of Service

Time of Service

A copy of the fax transmission record, or the courier or postal receipt may be required as evidence to support this Statement

Your Signature

Date

Signature of Person Who Served

DR12 15JUN94

Ce formulaire est également disponible en français.

Reply by the Applicant for Arbitration

Ontario Insurance Commission / Commission des assurances de l'Ontario

Reply by the Applicant for Arbitration

Arbitration File No.

Use this form to reply to any **point** made by the insurance company in its **Response** to your **application for arbitration**. You **must** reply to any **new** issues raised by the insurance company in their **Response**. If no new issues are raised by the insurance company this **Reply** is optional. You must serve a copy of the **Reply** on the Insurance Company **within 10 days of your receipt of the Insurance Company's Response**. You must also file the **Reply** and **a Statement of Service** with the Commission.

Personal information requested on this form is collected under the authority of the *Insurance Act* R.S.O. 1990, c.I.8., as amended. This information, including documents submitted with this form, will be used in the dispute resolution process for accident benefits. This information will be available to all parties to the proceeding. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group, Ontario Insurance Commission.

Applicant

Last Name | First Name

If you are represented and your representative has changed since you applied for arbitration, fill in the name of your new representative below.

Last Name | First Name

Firm | Your File No.

Street Address

City | Province | Postal Code

Phone Number ( ) | Fax Number ( )

Insurance Company

Company Name

Reply

Please reply to the insurance company's position on the itmes in dispute. Attach additional sheets if necessary.

Additional sheets attached. ☐

Signature

Name (Please Print) | Signature

Applicant ☐ Representative ☐ | Date

Ce formulaire est également disponible en français.

DR-17 (NOV-96)

Sample

Ontario Insurance Commission / Commission des assurances de l'Ontario

JOINT STATEMENT FOR NEUTRAL EVALUATION

THIS FORM MUST BE COMPLETED BY BOTH PARTIES AND RETURNED TO THE OIC ARBITRATION UNIT BY: DATE #1 (30 DAYS AFTER NEUTRAL EVALUATION COMMENCES).

To: **Mary Jones** **Fax: (416) 590-8462**
OIC Case Administrator

Re: **OIC FILE No A96-00001**
(JOHN SMITH & ABC INSURANCE COMPANY)

We hereby certify that all documents required for the neutral evaluation have been exchanged.

Listed below are the issues remaining in dispute that are to be submitted to the neutral evaluator. (Add more pages if required).

1. _____

2. _____

3. _____

The parties note the following dates (between DATE #2 [DATE #1 + 10 days] and DATE #3 [DATE2 + 25 days] are available for a half day session:

	Date:	AM / PM:	
1.	_____	_____	or
2.	_____	_____	

Signature

Applicant or Applicant's Representative	Insurer or Insurer's Representative
Date	Date

Sample

Ontario Insurance Commission / Commission des assurances de l'Ontario

Notice of Appeal

Use this form when you want to appeal an arbitration decision. **Appeals are only allowed on questions of law.**

You must file your completed *Notice of Appeal* with the Ontario Insurance Commission (address below) **within 30 days** of the date of the arbitration decision. The steps you must take are set out in this form.

If you have any questions or want more information, contact:

Appeals Unit
Dispute Resolution Group
Ontario Insurance Commission
5160 Yonge Street
15th Floor, Box 85
North York, Ontario M2N 6L9

In Toronto: (416) 590-7222
Toll Free: 1-800-517-2332, extension 7222
FAX: (416) 590-7077

Personal Information requested on this form is collected under the authority of the *Insurance Act* R.S.O. 1990, c. I.8. as amended. This information, including documents submitted with this notice, will be used in the dispute resolution process for accident benefits. This information will be available to all parties to the proceeding. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group.

DR-18 (JAN-97)

Ce formulaire est également disponible en français.

Appealing an Arbitration Decision...

Step 1:
Complete this *Notice of Appeal* form. If it is incomplete, it may be rejected.
After completing the form, you must serve a copy on the respondent (the other party). If the respondent was represented at the arbitration hearing by a lawyer, you should serve the *Notice of Appeal* on the lawyer. If not, serve the respondent.

Service may be done by personal delivery, courier, fax, regular mail, registered mail or any other method allowed by the Dispute Resolution Practice Code.

Then file the following with the Ontario Insurance Commission:
- Completed *Notice of Appeal*
- Original *Statement of Service* form stating when and how you served the respondent with the *Notice of Appeal*
- If you are an insured person, the $250 filing fee by cheque or money order made out to the **MINISTER OF FINANCE.**
  If you are an insurer, the Ontario Insurance Commission will invoice your company for the filing fee (**$250**) and the insurer assessment (**$500**).

Step 2:
Upon receiving a properly completed *Notice of Appeal, Statement of Service* and the application fee, the Ontario Insurance Commission will promptly acknowledge the appeal.

Step 3:
To oppose your appeal, the respondent must file a *Response to Appeal* within 20 days of receiving acknowledgement of the appeal from the Ontario Insurance Commission. You will get a copy of the *Response to Appeal* from the respondent.

Step 4:
After you receive the respondent's *Response to Appeal*, you can reply although a reply is not required. If you want to reply, you must file a *Reply by the Appellant* form within 10 days of receiving the respondent's *Response to Appeal*. You must also file a *Statement of Service* stating when and how you served the respondent with your *Reply by the Appellant*.

Step 5:
Unless the Appeal Adjudicator advises you differently, your written submissions must be served on the respondent and filed with the Ontario Insurance Commission within 30 days of the date your *Reply by the Appellant* was due. If a transcript is ordered, this time limit is extended to 30 days from receipt of the transcript.

Step 6:
The Appeal Adjudicator may decide the appeal with or without a hearing.

DR-18 (JAN-97)

How to Complete the *Notice of Appeal*

Details
This information can be found in the arbitration decision.

Appellant's Name and Address
Fill in completely. Provide any alternative addresses, phone numbers or fax numbers that will make it easier for us to contact you.

Appellant's Representative
You may choose to have someone represent you. Although many people are represented by a lawyer in an appeal, a lawyer is not required. If you have a representative, fill in the name, address and phone number of your representative. If it is a firm, please give the name of the firm in the box provided. **If your representative is NOT a lawyer, please provide written confirmation that the representative is authorized to act for you during the appeal. A minor (a person under the age of 18) or a person who is mentally incapable, must have a representative.**

Reasons for the Appeal
Appeals are only available on questions of law. If your appeal does not involve a question of law, it may be rejected. Briefly state what part(s) of the arbitration order you are appealing and the error(s) of law you claim the arbitrator made. Attach extra sheets if necessary. Your *Notice of Appeal* must be sufficiently detailed to allow the other party to respond. It is not necessary, however, for you to file your complete written submissions until later.

Action Sought
Briefly state the remedy or outcome you are seeking in your appeal.

Ce formulaire est également disponible en français.

Notice of Appeal

Ontario Insurance Commission / Commission des assurances de l'Ontario

Notice of Appeal

Arbitration Decision Details

Applicant

Arbitration File Number A-

Insurer(s)

Date of Arbitration Decision

Name of Arbitrator

Appellant's Name and Address

Mr. ☐ Mrs. ☐ Ms. ☐ Last Name First Name (or Insurer Name)

Street Address Phone Number

City Province Postal Code Fax Number

Appellant's Representative

Last Name First Name

Firm Your File No.

Street Address Phone Number

City Province Postal Code Fax Number

Reasons for the Appeal

Briefly explain the reasons for your appeal (questions of law only). Attach additional sheets if necessary.

Additional sheets attached. ☐

Action Sought from the Appeal

Briefly explain what outcome you are looking for in the appeal. Attach additional sheets if necesary.

Additional sheets attached. ☐

DR-18 (JAN-97)

Ce formulaire est également disponible en français.

Sample

For a complete set of the rules for appeals - see the Dispute Resolution Practice Code.

Note:
You may settle your dispute with the respondent directly at any time during the process.

Preliminary Matters

Transcript

Indicate if the arbitration hearing was recorded. If it was recorded, indicate if you have ordered a transcript of the hearing. If you do not intend to order a transcript, you must state why a transcript is not needed for the appeal.

Stay

The usual rule is that an appeal does not stop the arbitration order from taking effect. If you are asking that the arbitration order not go into effect, you must explain why the usual rule should not apply.

It is likely that the stay will be decided without further submissions, so your reasons should be as complete as possible.

Evidence

Appeals are usually decided based on the evidence presented at the arbitration hearing. The Appeal Adjudicator will have access to the arbitration exhibits and, therefore, it is not necessary to refile them.
If you want to rely on any additional or new evidence - documents or witnesses - you must explain what the evidence is and why it should be allowed in the appeal.

This issue may be decided without further submissions so your explanation should be as detailed as possible

Signature

Sign the form and return it to the Appeals Unit at the Ontario Insurance Commission.

Fee

If you are an insured person, be sure to enclose the filing fee of $250 by cheque or money order made out to the **MINISTER OF FINANCE. The application will be rejected if the filing fee is not enclosed.**
If you are an insurer, the Ontario Insurance Commission will invoice your company for the filing fee (**$250**) and the insurer assessment (**$500**).

DR-18 (JAN-97)

Ce formulaire est également disponible en français.

Sample

Notice of Appeal

Transcripts

Was the arbitration recorded? Yes ☐ No ☐

Are you ordering a transcript of the hearing? Yes ☐ If yes, have you ordered it? When do you expect to receive it?

No ☐ If no, briefly explain why a transcript is not needed for the appeal.

Additional sheets attached ☐

Stay

Are you asking for a Stay of the Arbitration Order? Yes ☐ No ☐ Briefly explain the reasons you are asking for a stay. Attach additional sheets if necessary.

Additional sheets attached ☐

Evidence

List any evidence that you intend to rely on that was not part of the arbitration hearing. Explain in detail why this evidence is necessary.

Additional sheets attached ☐

Signature

Name (Please Print) Title Appellant ☐ Representative ☐

Signature Date

DR-18 (JAN-97)

Total number of additional sheets attached

Ce formulaire est également disponible en français.

Sample

Ontario Insurance Commission / Commission des assurances de l'Ontario

Response to Appeal

Use this form if you want to oppose an appeal filed by another party to the arbitration hearing.

You must file this *Response to Appeal* form with the Ontario Insurance Commission (address below) **within 20 days** of receiving confirmation of the appeal from the Ontario Insurance Commission. The steps you must take are set out in this form.

If you have any questions or want more information, contact:

Appeals Unit
Dispute Resolution Group
Ontario Insurance Commission
5160 Yonge Street
15th Floor, Box 85
North York, Ontario M2N 6L9

In Toronto: (416) 590-7222
Toll Free: 1-800-517-2332, extension 7222
FAX: (416) 590-7077

Personal Information requested on this form is collected under the authority of the *Insurance Act* R.S.O. 1990, c. I.8. as amended. This information, including documents submitted with this notice, will be used in the dispute resolution process for accident benefits. This information will be available to all parties to the proceeding. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group.

DR-19 (JAN-97)

Ce formulaire est également disponible en français.

Responding to an appeal . . .

Upon receiving a properly completed *Notice of Appeal*, the Ontario Insurance Commission will promptly acknowledge the appeal by sending letters to all parties to the arbitration hearing.

If you want to oppose the appeal, you must respond **within 20 days** of receiving confirmation of the appeal from the Ontario Insurance Commission.

Step 1:
Complete this *Response to Appeal* form.
After completing the form, you must serve a copy on the appellant. If the *Notice of Appeal* shows that the appellant is represented, you must serve the representative. If not, serve the appellant.

Service may be done by personal delivery, courier, fax, regular mail, registered mail or any other method allowed by the Dispute Resolution Practice Code.

Then file the following with the Ontario Insurance Commission:

- Completed *Response to Appeal*
- Original *Statement of Service* form stating when and how you served the appellant with the *Response to Appeal*
- If you are an insured person, there is no fee for filing a *Response to Appeal*.
  If you are an insurer, the Ontario Insurance Commission will invoice your company the insurer assessment (**$500**).

"Cross appeals": If you want to appeal any part of the arbitration order, you must file your own *Notice of Appeal*. The rules for appeals apply to "cross-appeals," including time limits and filing fee **($250)**.

Step 2:
The appellant may file a *Reply by the Appellant* within 10 days of receiving your *Response to Appeal*, although this is an optional step.

Step 3:
When you receive the appellant's written submissions, your written submissions must then be served on the appellant and filed with the Ontario Insurance Commission within **20 days**.

Step 4:
The Appeal Adjudicator may decide the appeal with or without a hearing.

How to Complete the *Response to Appeal*

Appellant
This information can be found in the *Notice of Appeal*.

Respondent's Name and Address
Fill in completely. Provide any alternative addresses, phone numbers or fax numbers that will make it easier for us to contact you.

Respondent's Representative
You may choose to have someone represent you. Although many people are represented by a lawyer in an appeal, a lawyer is not required. If you have a representative, fill in the name, address and phone number of your representative. If it is a firm, please give the name of the firm in the box provided. If your representative is NOT a lawyer, please provide written confirmation that the representative is authorized to act for you during the appeal. A minor (a person under the age of 18) or a person who is mentally incapable, must have a representative.

Response to Appeal
Briefly state your response to the reasons for appeal set out in the *Notice of Appeal*. Attach extra sheets if necessary. Although you should state your position, it is not necessary for you to file your complete written submissions until later.

Response to Preliminary Matters
Provide your response to the preliminary matters raised in the *Notice of Appeal* (transcript, stay, evidence). The Appeals Adjudicator may decide the preliminary matters without further submissions, so your response should be set out in detail. Attach extra sheets if necessary.

Signature
Sign the form and return it to the Appeals Unit at the Ontario Insurance Commission

DR-19 (JAN-97)

Ce formulaire est également disponible en français.

Form I

Response to Appeal

Ontario Insurance Commission / Commission des assurances de l'Ontario

Response to Appeal

Appeal File No.
P -

Appellant

Name

Respondent's Name and Address

Mr. ☐ Mrs. ☐ Ms. ☐ | Last Name | First Name | (or Insurer Name)

Street Address | Phone Number

City | Province | Postal Code | Fax Number

Respondent's Representative

Last Name | First Name

Firm | Your File No.

Street Address | Phone Number

City | Province | Postal Code | Fax Number

Response to Appeal

Briefly explain your response to the appellant's reasons for appeal.

Additional sheets attached. ☐

Response to Preliminary Matters

Set out your response to the preliminary matters raised in the *Notice of Appeal* (transcript, stay, evidence).

Additional sheets attached. ☐

Signature

Name (Please Print) | Title | Respondent ☐ Representative ☐

Signature | Date

DR-19 (JAN-97)

Total number of additional sheets attached _____.

Ce formulaire est également disponible en français.

Sample

Form J

Reply by the Appellant

Ontario Insurance Commission / Commission des assurances de l'Ontario

Reply by the Appellant

Appeal File No. P -

Use this form if you want to reply to any point made by the respondent in the *Response to Appeal*. If you decide to reply, you must serve a copy of this *Reply* form on the respondent's representative or, if unrepresented, on the respondent, within **10 days** of receiving the respondent's *Response to Appeal*. You must then file the *Reply* and a *Statement of Service* with the Ontario Insurance Commission.

Unless the Appeal's Adjudicator advises you differently, your written submissions must be served and filed with the Ontario Insurance Commission **within 30 days** of the date your *Reply* was due. If a transcript is ordered, this time limit is extended to **30 days** from receipt of the transcript.

Personal Information requested on this form is collected under the authority of the *Insurance Act* R.S.O., 1990, c. I.8. as amended. This information, including documents submitted with this form, will be used in the dispute resolution process for accident benefits. This information will be available to all parties to the proceeding. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group, Ontario Insurance Commission.

Appellant

Name

Respondent

Name

Reply

Please reply to respondent's position on the items in dispute. Attach additional sheets if necessary.

Additional sheets attached. ☐

Signature

Name (Please Print) | Title | Appellant ☐ Representative ☐

Signature | Date

DR-22 (JAN-97)

Total number of additional sheets attached

Ce formulaire est également disponible en français.

Sample

Ontario Insurance Commission / Commission des assurances de l'Ontario

Application for Intervention

Use this *Application* to intervene in an appeal before the Ontario Insurance Commission. You must serve a copy of this *Application* on all parties to the Appeal. You must also file the *Application* and a *Statement of Service* with the Commission. Any party to the Appeal may support or object to this *Application* by filing written submissions with the Commisssion within **10 days** of being served with the *Application*. The submissions must include the party's reasons why the applicant should, or should not, be permitted to participate. You must serve a copy of the written submission on the representative of the person making the *Application*, if not represented, on the applicant. You must then file a *Statement of Service* with the Commission.

Personal information requested on this form is collected under the authority of the Insurance Act R.S.O. 1990, c. I.8 as amended. This information, including documents submitted with this form, will be used in the dispute resolution process for accident benefits. This information will be available to all parties to the proceeding. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group, Ontario Insurance Commission.

Appeal Case and Number

Appellant | and | Respondent

Appeal File Number P -

Applicant's Name and Address

Last Name | First Name | (or Insurer Name)

Mr☐ Mrs☐ Ms☐

Street Address | Phone No

City | Province | Postal Code | Fax No.

Applicant's Representative (if any)

Last Name | First Name

Firm | Your File No.

Street Address | Phone No.

City | Province | Postal Code | Fax No.

Submissions

I wish to make submissions on the following issues of law (include a reference to any statutory provision to be relied on):

☐ Additional sheets attached.

Documents

I am relying on the following documents for the application:

☐ Copies of documents are attached.

Signature

Name (Please print) | Title | Signature

Date

Applicant ☐ Representative ☐

Total number of additional sheets attached ___.

DR9 JAN-97

Ce formulaire est également disponible en français.

Ontario Insurance Commission / Commission des assurances de l'Ontario

Application for Variation/Revocation

Use this form when you want a variation or revocation of an arbitration or appeal decision.

An application for variation/revocation, instead of an appeal, is appropriate if the situation has changed since the hearing, new evidence has become available that was not available for the hearing, or there is some clear error in the decision (for example, the order does not correspond to the reasons for the decision).

After completing your *Application for Variation/Revocation* form, you must file one copy with the Ontario Insurance Commission (address below). The steps you must take are set out in this form.

If you have any questions or want more information, contact:

Appeals Unit
Dispute Resolution Group
Ontario Insurance Commission
5160 Yonge Street
15th Floor, Box 85
North York, Ontario M2N 6L9

In Toronto: (416) 590-7222
Toll Free: 1-800-517-2332, extension 7222
FAX: (416) 590-7077

Personal Information requested on this form is collected under the authority of the *Insurance Act* R.S.O. 1990, c. I.8. as amended. This information, including documents submitted with this notice, will be used in the dispute resolution process for accident benefits. This information will be available to all parties to the proceeding. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group.

DR-23 (JAN-97)

Ce formulaire est également disponible en français.

Applying for Variation or Revocation of an arbitration order . . .

Step 1:
Complete this *Application for Variation/Revocation* form. If it is incomplete, it may be rejected. After completing the form, you must serve a copy on the respondent (the other party). If the respondent was represented by a lawyer, you should serve the *Application for Variation/Revocation* on the lawyer. If not, serve the respondent.

Service may be done by personal delivery, courier, fax, regular mail, registered mail or any other method allowed by the Dispute Resolution Practice Code.

Then file the following with the Ontario Insurance Commission:

- Completed *Application for Variation/Revocation*
- Original *Statement of Service* form stating when and how you served the respondent with the *Application for Variation/Revocation*
- If you are an insured person, the **$100** filing fee by cheque or money order made out to the **MINISTER OF FINANCE.**
  If you are an insurer, the Ontario Insurance Commission will invoice your company for the filing fee (**$100**) and the insurer assessment (**$500**).

Step 2:
Upon receiving a properly completed *Application for Variation/Revocation*, *Statement of Service* and the application filing fee, the Ontario Insurance Commission will promptly acknowledge the application.

Step 3:
To oppose your application, the respondent must file a *Response to Variation/Revocation* within **20 days** of receiving acknowledgement of the application for variation/revocation from the Ontario Insurance Commission. You will get a copy of the *Response to Variation/Revocation* from the respondent.

Step 4:
After you receive the respondent's *Response to Variation/Revocation*, you can reply although a reply is not required. If you want to reply, you must file a *Reply by the Applicant to a Variation/Revocation* within **10 days** of receiving the respondent's *Response to Variation/Revocation*. You must also file a *Statement of Service* stating when and how you served the respondent with your *Reply*.

Step 5:
Unless the Director or Director's Delegate advises you differently, your written submissions must be served on the respondent and filed with the Ontario Insurance Commission within **30 days** of the date your *Reply* was due. If a transcript is ordered, this time limit is extended to **30 days** from receipt of the transcript.

How to Complete the *Application for Variation/Revocation*

Decision Details
This information can be found in the arbitration or appeal decision.

Applicant's Name and Address
Fill your name and address as the person or insurance company making this application for variation or revocation. Provide any alternative addresses, phone numbers or fax numbers that will make it easier for us to contact you.

Applicant's Representative
You may choose to have someone represent you. Although many people are represented by a lawyer in these proceedings, a lawyer is not required. If you have a representative, fill in the name, address and phone number of your representative. If it is a firm, please give the name of the firm in the box provided. **If your representative is NOT a lawyer, please provide written confirmation that the representative is authorized to act for you during the proceeding. A minor (a person under the age of 18) or a person who is mentally incapable, must have a representative.**

Reasons for the Application
Briefly state what part(s) of the arbitration or appeal decision you want varied or revoked and the reasons for your request. Attach extra sheets if necessary. Your *Application for Variation/Revocation* must be sufficiently detailed to allow the other party to respond. It is not necessary, however, for you to file your complete written submissions until later.

Action Sought
Briefly state the remedy or outcome you are seeking in your application for variation and revocation.

DR-23 (JAN-97)

Ce formulaire est également disponible en français.

Ontario Insurance Commission / Commission des assurances de l'Ontario

Application for Variation/Revocation

Decision Details

Applicant

Insurer(s)

Arbitration or Appeal File Number

Date of Decision

Name of Adjudicator

Applicant's Name and Address

Mr. ☐ Mrs. ☐ Ms. ☐ Last Name First Name (or Insurer Name)

Street Address Phone Number

City Province Postal Code Fax Number

Applicant's Representative

Last Name First Name

Firm Your File No.

Street Address Phone Number

City Province Postal Code Fax Number

Reasons for the Application for Variation/Revocation

Briefly explain the reasons for your application. Attach additional sheets if necessary.

Additional sheets attached. ☐

Action Sought from the Appeal

Briefly explain what outcome you are looking for in your application. Attach additional sheets if necesary.

Additional sheets attached. ☐

DR-23 (JAN-97)

Ce formulaire est également disponible en français.

Sample

Form L

Application for Variation/Revocation

Preliminary Matters

Transcript

Indicate if the hearing was recorded. If it was recorded, indicate if you have ordered a transcript of the hearing. If you do not intend to order a transcript, you must state why a transcript is not needed for the application.

For a complete set of the rules for variations/revocations - see the Dispute Resolution Practice Code.

Evidence

If you want to rely on any additional or new evidence in your application for variation or revocation, you must explain why it should be allowed. This should include whether the evidence could have been presented at the hearing and whether it would have led the adjudicator to a different decision.

Note:
You may settle your dispute with the respondent directly at any time during the process.

Signature

Sign the form and return it to the Appeals Unit at the Ontario Insurance Commission.

Fee

If you are an insured person, be sure to enclose the filing fee of **$100** by cheque or money order made out to the **MINISTER OF FINANCE. The application will be rejected if the filing fee is not enclosed.** If you are an insurer, the Ontario Insurance Commission will invoice your company for the filing fee (**$100**) and the insurer assessment (**$500**).

DR-23 (JAN-97)

Ce formulaire est également disponible en français.

Sample

Transcripts

Was the hearing recorded? Yes ☐ No ☐

Are you ordering a transcript of the hearing? Yes ☐ If yes, have you ordered it? When do you expect to receive it?
No ☐ If no, briefly explain why a transcript is not needed for the appeal.

Additional sheets attached. ☐

Evidence

List any evidence that you intend to rely upon that was not part of the hearing. Explain in detail why this evidence is necessary.

Additional sheets attached. ☐

Signature

Name (Please Print) Title Applicant ☐ Representative ☐

Signature Date

DR-23(JAN-97)

Total number of additional sheets attached __ __.

Ce formulaire est également disponible en français.

Sample

Ontario Insurance Commission / Commission des assurances de l'Ontario

Response to Variation/Revocation

Use this form if you want to oppose an application for variation or revocation filed by the other party.

You must file this *Response to Variation/Revocation* form with the Ontario Insurance Commission (address below) **within 20 days** of receiving confirmation of the application from the Ontario Insurance Commission. The steps you must take are set out in this form.

If you have any questions or want more information, contact:

Appeals Unit
Dispute Resolution Group
Ontario Insurance Commission
5160 Yonge Street
15th Floor, Box 85
North York, Ontario M2N 6L9

In Toronto: (416) 590-7222
Toll Free: 1-800-517-2332, extension 7222
FAX: (416) 590-7077

Personal Information requested on this form is collected under the authority of the *Insurance Act* R.S.O. 1990, c. I.8. as amended. This information, including documents submitted with this notice, will be used in the dispute resolution process for accident benefits. This information will be available to all parties to the proceeding. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group.

DR-20JAN-97)

Ce formulaire est également disponible en français.

Response to the Application for Variation/Revocation

Responding to an application for variation/revocation . . .

Upon receiving a properly completed *Application for Variation/Revocation*, the Ontario Insurance Commission will promptly acknowledge the application by sending letters to all parties to the arbitration or appeal.

If you want to oppose the application, you must respond within **20 days** of receiving confirmation of the application from the Ontario Insurance Commission.

Step 1:
Complete this *Response to Variation/Revocation* form. After completing the form, you must serve a copy on the applicant. If the *Application for Variation/Revocation* shows that the applicant is represented, you must serve the representative. If not, serve the applicant.

Service may be done by personal delivery, courier, fax, regular mail, registered mail or any other method allowed by the Dispute Resolution Practice Code.

Then file the following with the Ontario Insurance Commission:

- Completed *Response to Variation/Application*.
- Original *Statement of Service* form stating when and how you served the applicant with the *Response to Variation/Revocation*.
- If you are an insured person, there is no fee for filing a *Response to Variation/Revocation*. If you are an insurer, the Ontario Insurance Commission will invoice your company the insurer assessment (**$500**).

Step 2:
The applicant may file a *Reply by the Applicant to a Variation/Revocation* within 10 days of receiving your *Response to Variation/Revocation*, although this is an optional step.

Step 3:
When you receive the applicant's written submissions, your written submissions must then be served on the applicant and filed with the Ontario Insurance Commission within **20 days**.

Step 4:
The Director or Director's Delegate may decide the application for variation/revocation with or without a hearing.

DR-20 (JAN-97)

How to Complete the *Response to Variation/Revocation*

Applicant for Variation/Revocation
This information can be found in the *Application for Variation/Revocation*.

Respondent's Name and Address
Fill in completely. Provide any alternative addresses, phone numbers or fax numbers that will make it easier for us to contact you.

Respondent's Representative
You may choose to have someone represent you. Although many people are represented by a lawyer in these proceedings, a lawyer is not required. If you have a representative, fill in the name, address and phone number of your representative. If it is a firm, please give the name of the firm in the box provided. **If your representative is NOT a lawyer, please provide written confirmation that the representative is authorized to act for you during the proceeding. A minor (a person under the age of 18) or a person who is mentally incapable, must have a representative.**

Response to Application for Variation/Revocation
Briefly state your response to the reasons for appeal set out in the *Application for Variation/Revocation*. Attach extra sheets if necessary. Although you should state your position, it is not necessary for you to file your complete written submissions until later.

Response to Preliminary Matters
Provide your response to the preliminary matters raised in the *Application for Variation/Revocation* (transcript, evidence). The Director or Director's Delegate may decide the preliminary matters without further submissions, so your response should be set out in detail. Attach extra sheets if necessary.

Signature
Sign the form and return it to the Appeals Unit at the Ontario Insurance Commission.

Ce formulaire est également disponible en français.

Form M

Response to the Application for Variation/Revocation

Ontario Insurance Commission / Commission des assurances de l'Ontario

Response to Application for Variation/Revocation

Variation/Revocation File No.
P -

Applicant for Variation/Revocation

Name

Respondent's Name and Address

Mr. ☐ Mrs. ☐ Ms. ☐ | Last Name | First Name | (or Insurer Name)

Street Address | Phone Number

City | Province | Postal Code | Fax Number

Respondent's Representative

Last Name | First Name

Firm | Your File No.

Street Address | Phone Number

City | Province | Postal Code | Fax Number

Response to Application for Variation/Revocation

Briefly explain your response to the applicant's reasons for the application.

Additional sheets attached. ☐

Response to Preliminary Matters

Set out your response to the preliminary matters raised in the application (transcript, evidence).

Additional sheets attached. ☐

Signature

Name (Please Print) | Title | Respondent ☐ Representative ☐

Signature | Date

DR-20 (JAN-97)

Total number of additional sheets attached _____

Ce formulaire est également disponible en français.

Sample

Ontario Insurance Commission / Commission des assurances de l'Ontario

Reply by the Applicant to a Variation/Revocation

Variation/Revocation File No.
P -

Use this form if you want to reply to any point made by the respondent in the *Response to Variation/Revocation*. If you decide to reply, you must serve a copy of this *Reply* form on the respondent's representative or, if unrepresented, on the respondent, within **10** days of receiving the respondent's *Response to Variation/Revocation*. You must then file the *Reply* and a *Statement of Service* with the Ontario Insurance Commission.

Unless the Director or Director's Delegate advises you differently, your written submissions must be served and filed with the Ontario Insurance Commission within **30** days of the date your *Reply* was due. If a transcript is ordered, this time limit is extended to **30 days** from receipt of the transcript.

Personal Information requested on this form is collected under the authority of the *Insurance Act* R.S.O. 1990, c. I.8. as amended. This information, including documents submitted with this form, will be used in the dispute resolution process for accident benefits. This information will be available to all parties to the proceeding. Any questions about this collection of information may be directed to the Office of the Registrar, Dispute Resolution Group, Ontario Insurance Commission.

Applicant

Name

Respondent

Name

Reply

Please reply to respondent's position on the items in dispute. Attach additional sheets if necessary.

Additional sheets attached. ☐

Signature

Name (Please Print) | Title | Applicant ☐ Representative ☐

Signature | Date

DR-21 (JAN-97)

Total number of additional sheets attached ____

Ce formulaire est également disponible en français.

Sample

Ontario Insurance Commission / Commission des assurances de l'Ontario

This form is in quadruplicate. The first page goes to the **witness**; the second page goes to the **commission**; the third page goes to the **insurance company**; the last page goes to the **insured person**

Form 1

SUMMONS TO WITNESS

Insurance Act, R.S.O., 1990, Chapter I.8 as amended (the "Act")

SUMMONS TO A WITNESS BEFORE the Ontario Insurance Commission

Re: *(Parties) Commission File No. A -*

TO: *(name and address of witness)*

(For oral hearing)

YOU ARE REQUIRED TO ATTEND TO GIVE EVIDENCE at the hearing of this proceeding on *(day)*, *(date)*, at *(time)*, at *(place)*, and to remain until your attendance is no longer required.

YOU ARE REQUIRED TO BRING WITH YOU and produce at the hearing the following documents and things: *(set out the nature and date of each document and give sufficient particulars to identify each document and thing.)*

IF YOU FAIL TO ATTEND OR TO REMAIN IN ATTENDANCE AS THIS SUMMONS REQUIRES, THE ONTARIO COURT (GENERAL DIVISION) MAY ORDER THAT A WARRANT FOR YOUR ARREST BE ISSUED, OR THAT YOU BE PUNISHED IN THE SAME WAY AS FOR CONTEMPT OF THAT COURT.

(For electronic hearing)

YOU ARE REQUIRED TO PARTICIPATE IN AN ELECTRONIC HEARING on *(day)*, *(date)*, at *(time)*, in the following manner: *(Give sufficient particulars to enable witness to participate.)*

IF YOU FAIL TO PARTICIPATE IN THE HEARING IN ACCORDANCE WITH THE SUMMONS, THE ONTARIO COURT (GENERAL DIVISION) MAY ORDER THAT A WARRANT FOR YOUR ARREST BE ISSUED, OR THAT YOU BE PUNISHED IN THE SAME WAY AS FOR CONTEMPT OF THAT COURT.

Date _____ _____

_____
Ontario Insurance Commission
Office of the Registrar

Note: You are entitled to be paid the same fees or allowances for attending at or otherwise participating in the hearing as are paid to a person summoned to attend before the Ontario Court (General Division).

DR 11 (FEB-97)

Ontario Insurance Commission / Commission des assurances de l'Ontario

This form is in quadruplicate. The first page goes to the **witness**; the second page goes to the **commission**; the third page goes to the **insurance company**; the last page goes to the **insured person.**

Form 1

SUMMONS TO WITNESS

Insurance Act, R.S.O., 1990, Chapter I.8 as amended (the "Act")

SUMMONS TO A WITNESS BEFORE the Ontario Insurance Commission

Re:

TO:

(For oral hearing)

YOU ARE REQUIRED TO ATTEND TO GIVE EVIDENCE at the hearing of this proceeding on _____ (day), _____ (date), at _____ (time), at _____ (place) and to remain until your attendance is no longer required.

YOU ARE REQUIRED TO BRING WITH YOU and produce at the hearing the following documents and things: _____

_____

_____

IF YOU FAIL TO ATTEND OR TO REMAIN IN ATTENDANCE AS THIS SUMMONS REQUIRES, THE ONTARIO COURT (GENERAL DIVISION) MAY ORDER THAT A WARRANT FOR YOUR ARREST BE ISSUED, OR THAT YOU BE PUNISHED IN THE SAME WAY AS FOR CONTEMPT OF THAT COURT.

(For electronic hearing)

YOU ARE REQUIRED TO PARTICIPATE IN AN ELECTRONIC HEARING on _____ (day), _____ (date), at _____ (time), in the following manner: _____

_____

IF YOU FAIL TO PARTICIPATE IN THE HEARING IN ACCORDANCE WITH THE SUMMONS, THE ONTARIO COURT (GENERAL DIVISION) MAY ORDER THAT A WARRANT FOR YOUR ARREST BE ISSUED, OR THAT YOU BE PUNISHED IN THE SAME WAY AS FOR CONTEMPT OF THAT COURT.

Date _____

_____
Ontario Insurance Commission
Office of the Registrar

Note: You are entitled to be paid the same fees or allowances for attending at or otherwise participating in the hearing as are paid to a person summoned to attend before the Ontario Court (General Division).

DR 11 (FEB-97)

Ontario Insurance Commission

Affidavit of Service for a Summons

The purpose of this *Affidavit* is to verify that a copy of the document named was personally served on the named person. An *Affidavit of Service* must be prepared for service of a *Summons*.

OIC Case Name and Number

Insured Person

and

Insurance Company

OIC File Number

Declaration

I, _____, of the _____
(Full Name) (City, Town, etc.)

of _____ in the _____
(Name of City, Town, etc.) (County, Regional Municipality, etc.)

of _____ **SWEAR OR SOLEMNLY AFFIRM THAT:**
(Name of County, Regional Municipality)

(1) At _____ a.m./p.m. on _____,
(Time) (Day of Week)

the _____ of _____, 19 _____,
(Date) (Month) (Year)

I personally served _____
(Name of person served)

with a copy of _____
(Name of document served)

at _____.
(Location where document was served)

(2) I was able to identify the person by _____.
(State means of identification)

(3) For a Summons, I paid the appropriate attendance monies to the person above.

Signatures

Sworn (or Solemnly Affirmed) before me at the _____ of _____
(City, Town, etc.) (Name of City, Town, etc.)

in the _____ of _____
(County, Regional Municipality, etc.) (Name of County, Regional Municipality, etc.)

on this _____ of _____, 19_____.
(Date) (Month)

Signature of Commissioner of Oaths

Signature of Person Serving

DR13 15JUN94

Ce formulaire est également disponible en français.

Sample(s)

GRAND & TOY

VERSATILE 368 - 1 1/2"

BLACK	99568	NOIR
RED	99570	ROUGE
LT. BLUE	99583	BLEU
DK. BLUE	99569	BLEU
GREEN	99573	VERT
GREY	99571	GRIS
BURG.	99596	BOURG.
YELLOW	99572	JAUNE

Manufactured by/Fabriqué par
ACCO CANADA INC.,
Willowdale, Ont. M2H 2E2